U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration for Children, Youth and Families
Children's Bureau
National Center on Child Abuse and Neglect

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# SEXUAL ABUSE OF CHILDREN:
## *Selected Readings*

*Cover drawings are by victims of incest.*

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The editors would like to express their appreciation to the many people who contributed to the publication of this book. Our special thanks go to the staff of the Child Protection Center of Children's Hospital National Medical Center and their director, Marv Holman; to Douglas Besharov for his continuing support; and to Dr. Frederick C. Green for his patience and assistance throughout. We are particularly grateful to those women who were willing to share their own feelings and experiences with us.

This book is dedicated to Clara Jo Stember: artist, teacher, therapist, and friend to children. Clara Jo died in her sleep just before the book went to press. Her contributions to this book are only a small example of her pioneering work in the use of art therapy with sexually abused children and her fervent belief in the importance of creative, non-verbal expression. Her love and undaunted enthusiasm will be remembered not only by her young clients, but by the field as a whole.

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# FOREWORD

This book marks a departure from previous publications by the National Center on Child Abuse and Neglect. Rather than commissioning the efforts of one author or reprinting the collected works of others, we have attempted to draw together in this volume of selected readings a wide range of materials on the subject of child sexual abuse. To the book's core section on the etiology and short-term management of sexual abuse (Part I), written by staff of the Child Protection Center, Children's Hospital National Medical Center, Washington, D.C., we have added materials that deal specifically with incest, treatment and interviewing techniques, and sexual exploitation of children for commercial purposes.

In keeping with the limited state of knowledge concerning the dynamics and effective prevention and treatment of child sexual abuse, this book does not espouse a single point of view or a "correct" way of handling the problem. Rather, it presents a number of different perspectives from professionals who represent a variety of disciplines. It also contains a collection of writings by adult and teenage victims of child sexual abuse who have allowed us to print their stories and feelings in the hope that their experiences will enable professionals to better understand and help others like them.

The appendices contain several different hospital protocols developed in recent years to aid medical personnel in the physical examination and diagnosis of child sexual abuse cases. Although some of the procedures contained in the various protocols are duplicative, and many are not necessary for every type of case, we have chosen to reprint them in full in order to share the medical techniques that have been developed independently by professionals in various parts of the country.

Also contained in the appendices is a list of child abuse and neglect treatment programs that were either developed exclusively to treat child sexual abuse or that incorporate special components and resources to deal with this problem. The list is far from exhaustive; it contains only those programs that are known to the National Center or that have responded to requests for information by the National Center's Clearinghouse. Child sexual abuse programs that are not included in this list are encouraged to write to the National Center.

It is our hope that this book of selected readings not only will provide useful information for those who wish to learn more about the subject of child sexual abuse, but will serve as a resource for professionals and concerned citizens who seek to develop better treatment programs in their communities. Such resources are badly needed to prevent, identify, and treat this most insidious, emotionally laden and hidden form of child maltreatment. Unlike child battering or physical neglect, the physical and emotional effects of sexual abuse often are not immediately evident and, therefore, may be minimized or overlooked. In doing so, we not only leave children vulnerable to continuing abuse, but we fail to provide them with the necessary support to deal with what has been appropriately referred to as a "psychological time bomb;" the long-term effects of sexual exploitation.

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# PART I

## Introduction

The eight chapters that comprise Part I of this book were written by staff members from the Child Protection Center (CPC), Children's Hospital National Medical Center, Washington, D.C. In 1975, the CPC was funded by the National Center on Child Abuse and Neglect to work with abused and neglected children and their families. Shortly after the CPC opened, the hospital's emergency room and outpatient clinics began referring all children in cases in which sexual abuse was suspected. It soon became apparent that these cases demanded a special approach and that they were different from cases of child battering. The more we tried to define the problem and the services needed, the more interested we became in working with these children. Consequently, we undertook to systematize and apply current knowledge about the diagnosis and treatment of sexual abuse. The information presented in Part I is a synthesis of our research and clinical experience and the case management techniques we have found most useful.

One of the dilemmas which immediately confronted us relates to case identification and diagnosis. As the only pediatric hospital in a major metropolitan area, we receive a wide range of cases. Some are self-identified cases of incest or other sexual abuse; others present with more ambiguous symptoms or complaints. We have found that it is usually necessary to initiate services before there is a clear determination of all the facts. A four-year-old with venereal disease may or may not be sexually abused. An accusation of rape against an unsavory neighbor may or may not prove true. Denial of an incestuous relationship between father and daughter is one of the most common reactions of the mother, the father, and often, the daughter. In short, it was necessary to devise a service delivery system which would provide the child with adequate protection and support while permitting us time to assess the situation and develop a case management plan.

For assistance, we turned to traditional crisis theory. The crisis model enables the provision of immediate care and support in all cases of sexual abuse, including those in which the parents neither perpetrated the incident nor contributed to it through neglect. The model has the added advantage of providing a stabilizing and supportive entry point to more extensive services for those children and families who are found to want or need them. In our experience, such services are usually required in cases in which neglect of the child contributes to the abuse or in which the incident is perpetrated by a parent, guardian, or other close family member.

Child sexual abuse is a relatively unexplored area for researchers and many front-line service providers. While history and mythology give ample evidence that sexual abuse is not new, the nature and extent of this phenomenon are only now receiving recognition and investigation. One of the basic problems encountered in preparing these chapters was defining specifically what is meant by the term child sexual abuse. In the search for a concrete, inclusive definition, a review of the relevant literature and laws was undertaken. While this effort was invaluable in many ways, it failed to unearth a generic definition sufficiently broad to encompass the problem as a whole but sufficiently specific to ward off vagueness and ambiguity. Child sexual abuse is defined in various ways depending on the source, context, and purpose of the definition.

Some of the ambiguity in terms can be attributed to researchers who have based their definitions on the laws of their jurisdictions. Unfortunately, laws vary considerably from state to state, and most jurisdictions have both civil and criminal laws related to sex offenses involving children. Because child protection and therapeutic intervention are the primary objectives of the civil laws, while the criminal laws are designed to apprehend, try, and punish offenders, definitions may vary widely between the two codes.

In our own efforts to define child sexual abuse, we began with a broad concept of childhood sexual trauma, which we define as any childhood sexual experience that interferes with or has potential for interfering with a child's normal healthy development. This definition could include everything from an accidental genital injury to forcible rape. Certainly, any trauma to a child that has sexual implications requires especially sensitive management by service providers. However, as clinicians specifically charged with responsibility for identification and treatment of sexually abused children, we have found it useful to adopt a more explicit definition of the problem we confront. To clarify our thinking, we focused on the word abuse. For abuse to occur, a person *must be acted upon* in a way that is inappropriate or harmful. In this context, child sexual abuse can be defined as *contacts or interactions between a child and an adult when the child is being used as an object of gratification for adult sexual needs or desires.*

In keeping with our child-centered point of view, it would be most elegant if we could define the various types of sexual abuse according to the nature of the child's reactions to the experience. Unfortunately, little is known about the specific effects of sexual abuse on children. Existing studies and case reports in the psychiatric literature have produced conflicting opinions about the seriousness of such experiences.

It is commonly agreed, however, that the child's age and developmental status, the relationship of the abuser to the child, and the violence associated with the abuse are important variables in determining the child's reaction. In general, the closer the relationship and more violent the incident, the more difficult it will be for the child to cope with the experience. In addition, the reactions of the child's parents and of professionals who become involved in the case can contribute substantially—for better or for worse—to the child's ability to resolve the situation.

Given the range of variables and the lack of any reliable means of categorizing incidents of sexual abuse by the reactions of the children who experience them, we have found it most useful to classify these cases from the point of view of the relationships existing among those involved. In so doing, we have maintained our child-centered orientation; that is, we are interested in knowing the role or status the abuser has in the eyes of the child. We have found that a thorough understanding of this relationship is crucial to the development of an appropriate treatment plan. By necessary extension, this usually means we must also discover the relationship of the abuser within or to the child's family. In developing plans for therapeutic intervention, we have found it unwise to rely on preconceptions about family roles and structure. Rather, careful assessment of the unique characteristics of each family is needed. Within this framework, it is possible to differentiate four broad categories of child sexual abuse that reflect the relationship between the abuser and the child.

### Parental

The first category is comprised of those cases in which a child is sexually abused by a parent or true parent figure. Sexual abuse of a child by a natural parent is commonly referred to as incest and is thought by many to have the most serious personal and social consequences. The historical and social taboos against sexual relationships between blood-relations, especially parents and children, are strong. However, the term incest raises some troublesome issues. The natural parent may or may not be a significant figure in the child's life. The natural parent may never have accepted the role of parent to the child. On the other hand, someone else, related or unrelated, may have assumed this role. Unfortunately, we may be tempted to minimize the implications of a sexual relationship between a child and a father figure who is not recognized by the law or our social customs as a "real father." This may be true regardless of the duration or stability of the parent-child relationship and regardless of the child's emotional investment in the man as a father. If the sexual abuse is discovered, the extent of the child's needs may not be recognized and, as a result, the service intervention may be inadequate. In forming clinically useful definitions, therefore, a diagnosis of incest involving parents or parent figures must take into consideration the emotional and psychological relationship between the adult and the child, as well as social norms and legal definitions.

### Familial

The second category of relationships consists of those cases in which the abuser is a family member other than a parent or parent figure. The broadest definition of incest includes these cases and the incest statutes of most states prohibit sexual relations between siblings, grandparents and grandchildren, and uncles or aunts and nieces or nephews. Sexual relations between siblings are thought by some to be the most common, though least reported, form of incest. Certainly, very little is known about these relationships and their effects on the children involved. More commonly reported are cases of sexual abuse involving members of the child's extended family. In these cases, the quality of the relationship between the child and the adult may be of greater or lesser significance than the mere fact of relatedness. The child may see the abusing adult as a powerful figure in the family and as a source of support, approval, and nurturance, or the relationship between the two may be remote and involve little trust or regard. Treatment needs must be defined accordingly.

### Trusted Adult

The third category includes those cases in which the abuser is not a relative but is a significant person in the child's life. Because children do not limit their important attachments to family members, cases of sexual abuse involving persons outside the family require the same care in assessment as those involving relatives. An admired neighbor, a favorite teacher, a babysitter may be chosen as an object of the child's affection. At times, the child's trust is misplaced. When a child is sexually abused by a well-known and highly esteemed adult, whether the adult is a relative or not, trauma may result.

### Stranger

Cases in which a child is sexually abused by a stranger or remote acquaintance comprise the fourth and final category. While children are less likely to be abused by a "stranger in the park" than by people they know, such incidents do, of course, occur. Because no close relationship exists between the abuser and the child in these cases, other variables, such as the degree of violence associated with the incident and the reaction of the family, assume increased importance in determining the impact on the child.

The following chapters describe an approach to providing crisis intervention services to children who are victims of all forms of sexual abuse. They provide an outline of suggested case management procedures to be implemented upon intake and throughout the initial or crisis phase of treatment. The purpose of the intervention is to support and protect the child and to improve the parent's or other primary caregiver's capacity to respond appropriately to the child's needs. The model is based on the premise that most children will recover from an experience with sexual abuse when given optimal support, protection, and nurturance by professionals and family members.

# CHAPTER I

# Sexual Abuse of Children: An Overview of the Problem

Rayline A. De Vine, M.D.

Children are naturally interested in everything. They are curious, courageous, willing to learn, constantly striving to understand adult secrets, to grow up—to become part of the adult world. Yet sexual matters persistently evade their grasp. If children are curious about accessible matters, they are twice as curious about matters that are hidden from them. Sexual curiosity, sexual fantasies, sex play, masturbation, and adolescent sexual experimentation are considered normal parts of a child's development. In fact, children have been described as "polymorphous perverse," meaning that they can be led into a variety of sexual activities.[1] Occasionally, these sexual activities involve an adult, often an adult the child knows, trusts, and views as a dominant figure. This sexual involvement between child and adult has a harmful potential that far outweighs what may have been innocent, playful beginnings.

Sexual abuse of children is not a new problem or a rare occurrence. It is not easily identified or diagnosed; it rarely results in physical injury; and often goes unreported to authorities. Many of the common beliefs regarding sexual abuse are based on misinformation and hearsay. In order to understand and prevent sexual abuse, such myths must be dispelled. Warnings such as "Don't take candy from a stranger!" and "Don't accept rides from people you don't know!" are given to children in hopes of protecting them from sexual assault. Yet, most children are sexually abused by people they know and trust. Children who are sexually abused are not special children with special characteristics; they are not of one age, one sex, one race, or one social class. They are not victims of any particular offense. Their role in the offense, their disclosure of the incident, and their reaction to the assault all differ. In the last few months we have treated:

☐ A six-year-old boy who had gone to use the bathroom in a supermarket while his mother waited in the check-out line. While in the bathroom, he was subjected to anal sodomy by an older boy.

☐ A four-year-old girl who had a positive vaginal culture for gonorrhea. Initially, her older brother was believed to be the source of her infection. It was later found, however, that her mother's boyfriend was actually responsible.

☐ A nine-year-old girl who had to be examined by several physicians under court order because her mother claimed her father had been molesting her. The parents were involved in a custody suit.

☐ Two fourteen-year-old, run-away girls who had been beaten and raped after they were picked up while hitchhiking. They refused to obtain medical treatment out of fear of police involvement. They knew their physically abusive parents would be notified, and they would be forced to return home.

☐ A two-year-old girl who, according to her father, had been involved in homosexual activity with her mother. This later proved to be another custody suit.

☐ A fourteen-year-old girl who went to the local police station to ask for protection from her father. She had been involved in an incestuous relationship with him for the past five years; her mother refused to believe her; her relatives refused to help her.

It is clear that sexual abuse is not easy to define. Permissible childhood sexual behavior varies in accordance with cultural taboos and family and social tolerances. Yet, to work with sexually abused children and their families, some definition of the problem is needed. As discussed in the Introduction, sexual abuse can be defined as contacts or interactions between a child and an adult when the child is being used as an object of gratification for adult sexual needs or desires. It is an experience that interferes with or has potential for interfering with a child's normal, healthy development. It is an experience with which the child may not be able to cope physically, intellectually, or emotionally. Physically, the child may find the experience highly sexually stimulating but rarely satisfying.[1] Intellectually, the child's stage of cognitive development may not be sufficiently advanced to permit comprehension of the experience. Emotionally, the child may not be mature enough to isolate his or her own feelings from the feelings of others. Thus, a sexually abused child may suffer anxiety from excessive, unfulfilled physical stimulation,[3] distortions and misconceptions due to intellectual limitations, and emotional disturbances from his own and his incorporated feelings of guilt and shame.[4]

We are becoming more aware of the needs of sexually abused children as a result of recent efforts to address the needs of battered and neglected children. There are, of course, similarities in these cases, particularly when sexual abuse is perpetrated by a parent or guardian. However, as more information is gathered about these problems, it becomes increasingly evident that there are substantial differences between most cases of child sexual abuse and most cases of child battering. These differences are reflected in case identification and diagnosis, judicial handling, and the treatment needs of child and family. For example, battered children often have multiple old and new injuries which cannot be adequately explained by their parents. In such cases, the diagnosis of abuse can often be made on the basis of physical findings. Sexually abused children, however, rarely sustain physical injury; the diagnosis of sexual abuse may rest entirely on the history as given by the child.

Many battered children, because they are injured directly or indirectly by their caretakers, must be removed from their homes, at least temporarily. Sexually abused children are often returned home following initial treatment unless a parent or guardian is clearly responsible for the abuse or is unable or unwilling to protect the child from a recurrence of the abuse. Children who have been sexually abused by a parent or guardian may be removed from their homes until such time as the parent-offender is removed through legal proceedings. In cases of sexual abuse that are adjudicated under criminal law, the child victim is subjected to a complex and often lengthy legal process which includes giving testimony against the offender, often in an open courtroom.

Battered children and their families may require long-term assistance. Crisis intervention is often sufficient treatment in cases of forcible or non-forcible sexual assault by a stranger and in cases of non-forcible sexual abuse by a person known to the family when the parent's primary concern is protecting the child and meeting his or her needs. Willingness to accept help and high motivation to seek services are often characteristics of these families. Parent-child incest usually requires longer and more intensive therapeutic intervention. More intensive intervention also may be required in cases in which the parent of a sexually abused child seeks to protect the offender or is for some other reason unable to focus on the child's needs. Clearly, then, only certain kinds of sexual abuse lend themselves to the diagnosis and treatment plans used in cases of child battering. A new focus and new approach are needed in the management of many types of cases of sexual abuse of children.

It is difficult to determine the actual number of sexually abused children in the United States. The incidence of sexual abuse may be greater than the incidence of physical abuse.[2] For example, over a ten year period in one county in Minnesota, there were 5,000 reports of suspected child neglect, 660 cases of physical abuse, and 2,400 reports of child sexual abuse.[6]

Crimes against children also account for a large proportion of all reported sex offenses. From 1965 to 1969 in Washington, D.C., a third of all reported rape cases involved a victim under age 15; 13 percent were under age nine.[5] In a similar study of reported rapes in Philadelphia conducted during 1973, 12 percent of all victims were ten or younger and 40 percent 15 or younger.[10] Though these figures are alarming, it is believed that reported cases of childhood sexual abuse represent only a small proportion of the actual incidence of this problem.[13]

National estimates generated in 1969 by the American Humane Association indicate that each year there may be at least 4,000 cases of sexual abuse in every large city.[2] A retrospective study conducted by Landis in 1956 indicates that some form of childhood or adolescent sexual abuse may occur in as much as one-third of the population. In this survey of 1,800 middle-class college students, 35 percent of the females and 30 percent of the males reported a prior experience with sexual abuse. Of the 360 females who had such an experience, only half disclosed the abuse to their parents, and only a tenth of the incidents were reported to the police. Of the males in the study, only one in six even reported the incident to their parents.[7]

Children may keep an assault secret from their families for many reasons. They may fear rejection, blame, punishment, or abandonment; they may feel their parents will not believe them.[1] Boys are less likely to disclose abuse than girls.[7] Children in general are most likely to report a single assault by a stranger.[2, 7] The closer the relationship of the offender to the child or family, the less likely it is that the child will report the incident.[11] Thus, delay in reporting a sexual assault is common in childhood, as is the incidence of repeated assault.

Even when the abuse is disclosed, parents may be reluctant to report the incident to the police [11] or social service agencies. This reluctance may stem from cultural taboos; fears of social censure, blame, or punishment; lack of physical injury to the child; or apprehension about involving the child in legal proceedings. The identity of the offender may also affect the parents' decision to report. They may fear retaliation by the offender, or they may feel a need to protect an offender who is a family member or friend, especially if reporting the offense could precipitate the loss of economic or emotional support.

According to the 1969 study conducted by De Francis in two boroughs of New York City, up to a third of the cases that are reported to the police may be dropped before they come to trial, either because parents decide to withdraw the complaint or the offender cannot be positively identified. In this study, up to 44 percent of the cases taken to court were dismissed for lack of evidence.[2] In the study conducted by Peters in Philadelphia, among the group of 121 adolescents who reported being raped, 28 percent were urged to drop charges by the police. Of these, over half of the complainants reported that the police did not believe them.[10]

High estimates of the incidence of sexual abuse raise pressing questions about the nature of this phenomenon. Although generalizations are plagued with exceptions, we felt it useful to review and synthesize available studies of reported cases. From this undertaking, it appears that sexually abused children can range in age from infancy to young adulthood. In studies of victims under age 16, the average age was 11.[2, 8] Girls were more likely to be molested as pre-adolescents, while boys were somewhat older.[7] Among reported cases, female victims outnumbered males ten to one.[2, 8, 15, 17]

Types of offenses against girls included exhibitionism, fondling, genital contact, vaginal, oral or anal intercourse. In Landis's study, over half of the sexually abusive experiences reported by college girls were encounters with exhibitionists; 25 percent gave a history of fondling by an adult; and only about ten percent reported that attempts at penetration were involved in the abuse.[7] Studies that reviewed reported cases and/or court cases, however, showed a higher incidence of rape and sodomy.[2, 15] Nearly all male experiences with sexual abuse involved a male offender and included fondling, mutual masturbation, anal intercourse, and fellatio.[4, 7] Several studies indicate that nearly half of the child victims were involved in more than one experience with sexual abuse;[2, 7, 15] some of these offenses recurred over a period of weeks or years.[2, 15]

At least half, and possibly as many as 80 percent, of all child victims were sexually abused by people known to them.[1, 2, 8, 10, 13, 15, 18] Parents, parent-substitutes, or relatives were responsible for from 30 percent [2, 8, 18] to 50 percent [1, 13] of all cases. In general, studies indicate that sexual abuse of children occurs most frequently during the summer,[8] usually indoors,[2, 10] and during the late afternoon or early evening.[2, 8, 10] Over one-third of the assaults on children were reported to occur in the child's home, while 20 percent occurred in the home of the offender.[2, 10]

Because of the child's trusting relationship with the offender, the use of physical force rarely is necessary to engage a child in sexual activity. The cooperation of the child can be obtained through the adult's position of dominance, a bribe of material goods, a threat of physical violence, or a misrepresentation of moral standards.[1, 2] In complying with the adult's wishes, a child also may be attempting to fulfill needs that normally are met in other ways. For example, a child may cooperate out of a need for love, affection, attention, or a sense of loyalty to the adult.[1] Conversely, a need to defy a parental figure, express anger about a chaotic home life, or act out sexual conflicts may make a child vulnerable to sexual exploitation.[18]

Inadequate supervision by parents and failure to set proper controls for a child's behavior may be contributing factors to sexual abuse. It has been estimated that parents directly or indirectly contribute to over 70 percent of all cases of sexual abuse.[2] In De Francis's study, 41 percent of the families showed behavior indicative of psychosocial disturbances. In a third of these families, there was a history of a prior sexual offense involving a family member; 11 percent of the mothers had been child-victims themselves.[2]

Since violent encounters are unusual, the proportion of children who suffer serious physical injury is low. Hayman and Lanza found that as few as four percent of young female assault victims needed outpatient medical care for major injuries (usually vaginal or vaginoperineal tears); and only three percent required hospitalization.[5] The incidence of venereal disease following sexual assault also is low. For example, in one group of 418 sexually abused girls 14 and younger, less than one percent contracted gonorrhea.[17] However, since gonorrhea is transmitted by sexual contact, it is an important indicator of childhood sexual abuse.

Children's immediate reactions to an assault vary. Peters found that 11 percent of 64 child victims reported that they no longer felt safe where they lived; 20 percent began to eat less; 30 percent showed changes in sleeping habits; and 20 percent had nightmares. Of those in school, ten percent stopped going.[9, 10] Landis found that approximately half of the victims surveyed recalled the abusive experience as frightening, shocking, or emotionally upsetting.[7] In the interviews conducted by De Francis with child victims and their parents shortly after a reported incident of sexual abuse, two-thirds of the children were found to have some form of identifiable emotional disturbance and 14 percent were severely disturbed. Among these children, the most common reactions were pronounced feelings of guilt and shame and loss of self-esteem.[2]

Adolescent victims may be more likely to encounter physical force or violence than younger children. For example, of 121 cases of rape reported by adolescents in Philadelphia, 86 percent involved forced intercourse. After the assault, 42 percent of the victims showed changes in eating habits; 38 percent showed changes in sleeping habits; and 34 percent reported disturbing dreams and nightmares.[9, 10]

Both the initial and the long-term effects of a sexual assault on a child are closely related to the child's age and relative maturity, the child's relationship to the offender, the degree of force or violence associated with the offense, the family's and society's reaction to the assault, the prior existence of any family pathology, and the legal process.[11, 12] In general, it appears that the closer the offender-child relationship, the more invasive or violent the assault, the more disrupted the home, and the longer the court process, the more likely it is that the initial emotional impact of the abuse will be stressful and that psychological damage will result.

Just as most studies of victims of sexual abuse focus on reported cases, most studies of offenders are conducted with those who have been apprehended. For the most part, these studies have dealt with sex offenders in general; few have focused on the particular characteristics of sex offenders who commit crimes against children. From the information available, it appears that the adult who is convicted of sexually abusing a child usually does not fit the stereotype of a mental defective or the clinical category of pedophilia (see Chapter VII). Most offenders are male; their average age is about 30.[2, 8, 15] In one study, 80 percent had at least attended high school, and 60 percent had an adequate job history.[18] Half of these offenders had been charged with at least one criminal complaint prior to the offense; and approximately two-thirds were described as having some personality disorder, though few were psychotic.[15] Alcohol may play a significant role in many sex offenses against children;[5, 14] some studies show that as many as a quarter of the offenders have a history of an excessive use of alcohol.[15] [16]

Although sex offenders cannot be stereotyped, and the role of the child in the offense varies, it is not difficult to assign responsibility when sexual intimacy occurs between an adult and child. Whatever the child's needs, it is the adult who must exercise control. Although children sometimes find the moment pleasurable, the attention gratifying, they cannot and should not be blamed for the sexual activity. This responsibility clearly rests with the adult.

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# CHAPTER II
# Developmental Sexuality

Karen M. Leaman, R.N., M.S.N., and Anne Lowe Knasel, M.D.

The impact of sexual abuse is felt both physically and emotionally. It is important, therefore, that those who work with sexually abused children have a firm foundation in the facts of both physical and psychological development. Because children are evolving, ever-changing beings, there is a continuum of "normal" in all aspects of their growth. This chapter is intended to provide a broad overview of the developmental process as it relates to normal childhood sexuality.

The sexual identity of a child is determined at conception by the normal sex chromosomes contributed by each parent. At birth, infants are biologically complete with the appropriate internal and external sexual organs. During the first year and a half of life, children are truly sensual beings in that they do not think about the world, but rather, experience it directly with their bodies. They display a repetoire of behaviors that includes survival reflexes which inspire social interaction and attention from adults. This first period of life is often referred to as the oral stage of growth and development because the sucking reflex, in particular, provides the infant with much pleasure and gratification. Pleasure is also derived from other sensory experiences, such as touching, looking, and listening. Holding and cuddling are vital for the infant's very survival, as well as for healthy emotional development.

Infants' sensorimotor skills and understanding of the world gradually improve through physical contact and nurturing from a mother or mother-figure. If parents respond to their child's needs in a thoughtful and caring manner, a trusting relationship develops between them. From this vantage point of security, children learn that they are worthy of comfort and love and that their world is a safe place. This kind of learning helps them develop feelings of self-esteem and autonomy and prepares the way for another stage of growth and development.

Children between the ages of approximately two and four are traversing what is called the anal stage of development. It is during this stage that the child struggles with himself, and sometimes battles with his caregiver, over bowel and bladder control. The desired result cannot be accomplished, however, if toilet training is begun before the child is physically mature enough to master control of the necessary muscles.

As motor skills improve, children begin to achieve some sense of independence through walking and talking. To the dismay of their parents, they learn to say no, and often say it very assertively. For the first time, they can exert some control over their environment, deciding which toys to play with, where to walk, when to ask for water.

Their thinking skills improve. Although their perceptions are very self-oriented and they are unable to see any point of view other than their own, they work very hard to understand their world. When parents set appropriate limits for behavior during this period, children gradually learn that their wants and needs cannot always be satisfied immediately. Therefore, in order to stay in their parents' good graces, children attempt to behave in more socially acceptable ways and learn to wait for gratification of their wishes.

Eventually, children internalize many of the attitudes they perceive in their parents. Their concepts of right and wrong usually derive directly from parental reactions. "Badness" is equated with those things that parents frown upon; "goodness" is associated with conduct that meets with parental approval. This process leads to the development of the internal controls which govern a child's behavior. The nature of these internalized attitudes and controls forms the basis for the way children feel about themselves and their environment.

The phallic stage of development usually occurs between the ages of four and six. During this period, children become increasingly aware of their body parts and differences between the sexes. They find that touching their genitals produces pleasurable sensations. Self-stimulation or masturbation is normal among children, particularly in this age range. Since children's play during these years is also their work, their increasing interest in sexual matters also may be expressed in sex play with toys, friends, or siblings. By setting nonpunitive limits on these behaviors, parents are able to help their children differentiate socially acceptable public conduct from private and personal activities.

As children begin to develop a clearer understanding of sexual roles, they test out their sexual feelings toward their parents through a phenomenon which is referred to as the

Oedipal conflict in boys and the Electra conflict in girls. This phenomenon can be characterized as a family romance. Initially, children develop a romantic attachment to the parent of the opposite sex. They become disappointed when the parent does not respond to their overtures. Consequently, they begin to identify more strongly with the parent of the same sex, in hopes of making themselves more attractive to the desired parent. Often, this produces childhood versions of adult seductive behavior; little boys may swagger, strut, and tease, while little girls may be coy or coquettish. Identification with the same-sex parent helps children clarify and strengthen their own sexual image. In later years, this identification will help them develop healthy relationships with members of the opposite sex who can fulfill needs that parents cannot. When parents are supportive and consistent about family roles and functions, children usually work through the Oedipal/Electra conflict with a minimum amount of difficulty.

During early and middle childhood, children have many fantasies about sex and sexual relationships. These fantasies incorporate things they observe or are told, as well as their own private store of physical and emotional experiences. Their thought processes become more and more complex. However, until they reach age six or seven, children have difficulty separating internal experience from external reality. This confusion means that children may attach equal weight to fact and fantasy and find both equally "true" at times in explaining their world.

Between the ages of six and twelve, children are acquiring new thinking skills which usually are channeled into an intense interest in learning; they become actively involved in school activities, sports and games, and social relationships. These years have been described as the latency period of sexual development. Sexual curiosity remains alive, although sex play may be more discrete. Jump rope rhymes contain many sexual

## TABLE

### Developmental Sexuality

| | Female | Male |
|---|---|---|
| **Birth Through First Weeks of Life** | All sex organs are present. The vagina, upon the withdrawal of maternal estrogen, may have a white discharge, and the uterine lining may bleed lightly.<br>Hymenal orifice ≈ 0.5 cm. | All sex organs are present.<br>Testes may or may not be descended into the scrotum. |
| **Infancy Through Childhood** | Sex organs increase somewhat in size.<br>The lack of estrogen causes the vaginal lining to be thin and dry and to have an alkaline pH, making it susceptible to infection and trauma.<br>Hymenal orifice ≈ 0.7 cm. | Sex organs increase somewhat in size.<br>Volume of testes 1-3 ml. |
| **Prepuberty Through Puberty** | 9-10<br>Increased estrogen production.<br>Growth of pelvic bones, nipple budding.<br>Hymenal orifice ≈ 1.0 cm. | 12-13<br>Increased androgen production, penis and testes increase in size (testes volume > 3 ml); appearance beginning of pubic hair, height growth spurt, voice changes. |
| | 10-11<br>Breast budding, appearance of pubic hair, height growth spurt. | 13-14<br>Increased pubic hair, beginning of nocturnal emissions. Spermatogenesis begins. |
| | 11-12<br>Estrogen influence causes vaginal lining to thicken and changes secretion to acid pH which makes the vagina resistant to bacterial infection. | 15-16<br>Growth of axillary hair, adult testes volume ≈ 12-25 ml. |
| | 12-14<br>Further breast growth. Axillary hair develops. Increase in pubic hair.<br>Menarche: cycle often irregular; ovulation may or may not occur. | |

references; "dirty" words have considerable appeal; and children may engage in comparative viewing of their growing bodies. In fact, as is shown in the accompanying table, little change takes place in the sexual organs of children during these years, except for a slow increase in size. It should be noted, however, that female children between infancy and puberty produce scant estrogen, and, therefore, the lining of the vagina is thin and relatively dry, making it susceptible to infection.

The years ten through twelve (prepuberty) are sometimes called the "homosexual" years. Both boys and girls enter into same-sex friendships which assume great importance. Children may fight jealously over "best friends;" boys say they hate girls and vice-versa. Through such intense friendships, children prepare themselves for adolescence and boy-girl relationships.

Adolescence is often an especially stressful time for children. Puberty usually begins around age ten in girls and a year later in boys; major physiological changes are usually completed by the time an adolescent is 14 or 15. The pronounced changes in body configuration and the upsurge in hormone production during these years arouses strong sexual feelings in teenagers. Sexually oriented dreams and fantasies can become quite dominant and even disturbing. Masturbation may become a frequent activity, although the adolescent may view this as shameful or dangerous.

Gradually, and sometimes painfully, adolescents assume the roles they have been preparing for since birth. Opposite sex friendships, dating, romantic attachments, and sexual experimentation become increasingly important. Normal adolescent conflicts over independence and separation from the family may also be expressed in a sexual mode. Teenagers may use sexual relationships to put distance between themselves and their families. Unfortunately, there is ample evidence in statistics related to adolescent pregnancy, abortion, and venereal disease to indicate that teenagers frequently become involved in sexual activity without adequate information about sexual hygiene and sex-related body processes. However, the adolescent's intellectual growth and maturity can help in dealing with the conflicts that burden these years. If teenagers have been successful in achieving previous developmental milestones, they will be able to enter young adulthood with a secure self-image and feelings of self-worth.

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# CHAPTER III

# The Sexually Abused Child in the Emergency Room

Raylene A. De Vine, M.D.

*Susan, an attractive, shy, and frightened six-year-old, was brought to the hospital emergency room by her father. Her mother had found blood in her panties that morning. Her father was agitated, confused, and embarrassed. He was cooperative, but obviously at a loss to explain or understand the possibility of sexual abuse of his daughter.*

*Susan separated willingly from her father but refused to talk; she answered friendly questions with monosyllables. When questioned about sexual activity, she turned her face away and refused to answer. Initial attempts to obtain a history were futile; a nurse and two physicians all took turns interviewing her to no avail. A third physician spent 45 minutes with her and, by engaging in games and role reversal, obtained a story which gave the impression that she had had a sexual contact with an adult male. Apparently, her older sister's boyfriend had molested her that morning in the downstairs entrance hall to her home.*

*When this story was relayed to her father, he said it was impossible. He insisted she had been assaulted the day before by an elderly man in the neighborhood who frequently gave children money and candy and invited them into his apartment. Susan had been warned about this man. The father repeatedly asked the child to admit to this history and scolded her for her disobedience. Susan remained mute.*

*A physical examination of Susan was accomplished with much difficulty; she had to be restrained by two nurses and an aide for the genital examination. She was examined twice, initially with a vaginal speculum, later with a nasal speculum; multiple cotton swabs were used to obtain vaginal and anal cultures. She cried, screamed, and resisted during the entire examination and re-examination. Physical findings were minimal; the impression was moderate erythema and stretching of the vaginal opening, indicating probable sexual assault. After the genital exam, blood was drawn for a syphilis test; again the child had to be restrained. She was then left unclothed on a hospital stretcher. Her father was called to stay with her. As soon as he entered the room, he began to question her in an angry, insistent tone.*

*Soon, the police arrived and immediately demanded the results of the physical examination. After a brief discussion with the physician and the child's father, they entered the examining room where the naked child remained on the hospital stretcher. Their first question to her was, "Has someone been messing with you?" She refused to answer.*

*The child never said another word while in the hospital. She left with her father and the police to find the man who had assaulted her.*

As this example shows, the impact of a sexual assault on a child and many of its damaging effects can result less from the abusive incident itself than from adult reactions to and management of the incident. For this reason, it is possible to prevent much of the damage caused by childhood sexual abuse, even after the actual assault has occurred. Prevention can begin as soon as the child and family arrive in the hospital emergency room.

Most parents react with alarm when they suspect that their child has been sexually abused. Their reactions often reflect feelings of disbelief, embarrassment, anger, fear, grief, and guilt. These feelings may be confused and undirected, or they may be directed inward toward themselves, or outward toward the suspected offender, or even the child. If one of the parents is the suspected offender, the emotional conflicts of family members may be even more pronounced.

To a child, who may have had little understanding of the significance of the incident at the time it occurred, these intense emotional reactions on the part of adults can be frightening and confusing. Children tend to incorporate the reactions of adults. They have not yet learned to separate what they feel from what they perceive others as feeling. When a sexually abused child is confronted with and incorporates strong negative reactions, the abusive experience may take on new significance; its immediate impact may be intensified, and the possibility of long-term negative effects increased.

When parents and children in this state of crisis arrive in the emergency room, it is important that they be received with special consideration. All health personnel who come in contact with the family have an opportunity to help stabilize the situation. If curiosity and speculation are minimized, if parents are helped to regain composure and perspective, and if the child is treated with respect and sensitivity throughout the initial interview and physical examination, many of the effects of the crisis can be alleviated, and many of the family's needs can be met.

A complaint of sexual abuse always should be taken seriously. In general, the possibility of sexual abuse should be considered when there is someone who claims to be an eyewitness, when the child confides in someone about the incident or hints about involvement in sexual activity, when the child's play with peers or dolls persistently indicates inappropriate sexual behavior, when suspicious stains or blood are found on the child's underwear, when the child complains of pain in the anal/genital area, or when the child is found to have venereal disease. Often, however, there is no eyewitness and little or no physical evidence to support the allegation of abuse. This does not negate the complaint. Any allegation of sexual abuse, whether true or false, is a cry for help.

The initial emergency room interviews with child and family are extremely important and can set the tone for all that follows. The purpose of these interviews is not to find out exactly who did what to whom nor to prove or disprove the story presented. The primary objectives are to determine the nature of the child's problems and how to prevent further problems, to understand the functioning of the family and how best to help in bringing about a satisfactory resolution to the crisis. A sensitive and patient interviewer, one who can communicate sincere concern and understanding of the family's conflicts and distress, usually can gain the confidence of both child and parents and obtain the needed information.

### Interviewing Parent and Child

Parents and child should be interviewed separately to permit each family member to tell his or her story in confidence and to provide parents with time to work through their emotional reactions without communicating their distress to the child. Children are sometimes reluctant to part from their families and may need to be reassured that their parents approve of this separation and will be nearby if needed. Initially, the child, accompanied by a staff member, should be taken to a quiet, private room and given some simple, age-appropriate activity, such as reading or coloring. This time is important to the child, as it provides an opportunity to adjust to new people and surroundings; the staff member can contribute to this adjustment by establishing an atmosphere of trust and acceptance. Questioning of any kind, and especially about the assault, should be avoided at this time.

This interval also provides an opportunity to interview the parents—again, in a quiet, private room. Frequently, it is necessary to help parents calm down and redirect their energies into answering simple, non-judgmental questions. It is important that they feel free to ventilate and discuss their feelings, fears, and expectations. Often, they need to be reassured that the problem is understandable and manageable. The kind of information needed from the family includes why they feel their child has been assaulted, any recent changes in the child's behavior, and an overview of the family structure and relationships. In some cases, parents may be reluctant to reveal their suspicions or knowledge about the identity of the offender, especially if a parent, other relative, or valued family friend is suspected. The interviewer should be sensitive to this possibility, particularly because protecting the child from re-assault is a critical and immediate concern. A more detailed discussion of parents' initial reactions to sexual assault of their child can be found in Chapter V.

In interviewing the child, it is important to remember that obtaining a history is the primary consideration and not who obtains that history. A one-to-one interview is usually most rewarding. While interviewing techniques vary according to the age of the child, problems that must be overcome at all ages include the child's general anxieties and fears, the child's specific resistance to talking about sexual matters, and the child's sexual knowledge and vocabulary. Early in the interview, it is important to establish rapport with the child by asking questions that will give some overall sense of the child as a person, including information about daily activities and ways of relating to people.

In questioning children about sexual assault, we have found that a frank, direct approach is best. They usually know why they have been brought to the hospital, and evasive or self-conscious questioning only allows tension to build. Children may come to see the interview as a game in which they playfully withhold information.

Another problem that may interfere with the interviewer's ability to gather information about the sexual assault is the child's vocabulary. All children have their own words for describing the vagina, anus, penis, and other parts of the body. This special vocabulary may be totally unfamiliar or even uncomfortable for the interviewer. However, once learned, the child's words should be used. Frequently, parents can supply these terms in advance. If not, it is helpful to have dolls available in the interview room. The examiner can simply ask the child to name the doll's body parts, an activity which is agreeable to most children. Such dolls also can be used by preverbal or resistant children to illustrate what happened to them.

Occasionally, children find it very difficult to discuss their problems; they may refuse to respond to any type of direct questioning. Play therapy or role playing can be effective interviewing techniques in such cases. For example, in one recent case a four-year-old with gonorrhea was reluctant to talk about sex play activities that could have transmitted the disease. The physician reversed roles with the child, leading to the following exchange:

**Doctor:** "Now let's play that *you* are the doctor and I am the one who is sick. You ask *me* how I got sick."
**Child:** "O.K. I am the doctor. How did you get sick?"
**Doctor:** "Guess."
**Child:** "Did you get it on a bus?"
**Doctor:** "No."
**Child:** "Did you get it from your teddy bear?"
**Doctor:** "No."
**Child:** "Did you get it from your cousin?"
**Doctor:** "Maybe so."

Subsequent tests revealed that two of the child's cousins, ages five and seven, were indeed infected with gonorrhea.

If a child refuses, after gentle prodding, to discuss the assault, it is better to desist and attempt to obtain a history at a later time. The child should not be subjected to repeated questioning by many adults in hopes of finding the "right person" in whom the child will confide. Wait! Usually, a skilled, sensitive, and patient interviewer will be able to obtain the necessary facts. Remember, interview techniques usually improve with practice; skilled interviewing is learned by doing.

Sharing of information obtained from the child's interview is a sensitive issue. Whenever possible, it is best to respect the child's wishes in this matter. At times, however, factors such as ensuring the protection of the child or complying with legal requirements will have to take precedence. By explaining the need for disclosure and the type of information to be shared, the examiner and child usually can come to an agreement.

Older children may be especially reluctant to have their parents told everything they have disclosed. In younger children, this need for confidence may not be expressed directly, but they may feel guilt or anxiety and even fear punishment from their parents. Therefore, it is important to be aware of the child's concerns and to share these concerns with parents in a constructive manner.

Sharing information about the identity of the offender should be approached with special care, as this may evoke strong emotional reactions from parents. This is especially true when the offender is identified as a parent, other family member, or friend. In such cases, ensuring the safety of the child and assessing the family's need for follow-up services are of critical concern.

## The Physical Examination

The physical examination usually follows immediately after the interview with the child. This exam and its results are considered an integral part of the diagnosis of sexual abuse. Too often, however, the examination takes on a false importance. Many parents depend on physical findings to confirm or disprove their child's story of assault. Police officers and prosecutors rely on positive findings for legal evidence. When the results of the examination are inconclusive, as is so often the case, everyone involved may feel dissatisfied. Regardless of the physical findings, the needs of the child must be met.

In our examination of sexually abused children, we have three primary concerns: medical, psychological, and legal. First, a medical examination is needed to assess physical injury, to provide treatment, and to obtain cultures for venereal disease. Second, the examination may provide information useful in reassuring the child and family that no permanent damage has occurred and that future childbearing potential has not been affected. Third, the exam may yield physical findings that can be used as legal evidence to corroborate the child's story.

Prior to the physical examination, it is helpful to meet with parents to discuss their expectations, to explain the limitations of the exam, and to answer any questions they may have about the specific procedures that will be used. It is important to reassure the family that all pertinent findings will be shared with them.

Unless the child is very young, it is usually best if parents are not present during the examination. An anxious mother may communicate her apprehension to her child, making it more difficult to gain the child's cooperation. An experienced nurse or other staff member should be at the child's side at all times, and the separation from family members should be done with the parents' approval and the child's consent.

The child should remain dressed until immediately prior to the exam. The state of dress and any torn or soiled clothing should be noted. Any clothing that is stained with secretions should be placed in a plastic bag and labeled, as it may be needed for legal evidence.

A general physical examination should precede the genito-urinary (G/U) exam. Note bruises, lacerations, and other signs of trauma. It has been found that at least 50 percent of all sexually abused children will have at least one sign of general or gynecological trauma if examined within one week of the assault.[2] However, these signs of trauma usually are insufficient to support or negate the complaint of sexual assault.

The child may be particularly apprehensive about the genito-urinary exam, and the physician should address this concern. The G/U exam can be presented as a necessary part of the physical exam, as a way of insuring the child's good health, and as a means of finding answers to his or her questions. If the child is moderately apprehensive, mild sedation can be used. If there is bleeding from an unknown site or suture repair is needed, it will be necessary to use general anesthesia. If the child is too distraught to tolerate further stress, infrequently it may be necessary to postpone the examination. In making this decision, the physician should be aware that a postponement may result in a loss of legal evidence.

In conducting the G/U exam, patience, sensitivity to the child's needs, and a reassuring attitude are of utmost importance. Forcing a child to submit to a gynecological examination can be more assaultive than the original incident of abuse. A rapid, insensitive exam, done under highly emotionally charged circumstances, can be perceived by the child as a repetition of the assault, reinforcing anxieties and fantasies.[8] [9] It is recommended that a physician of the same sex as the child perform the exam, especially if the assault was committed by a member of the opposite sex or the child appears to be especially modest. If any instrument is used, even a cotton-tipped swab, show it to the child first. Comments such as the following can be helpful:

- ☐ "I just want to have a look to make sure you are all right."
- ☐ "I know you are a little afraid and it is hard for you to lie still, but if you help me it will be easier and over sooner."
- ☐ "I will explain everything I am doing and try not to hurt you. If you want me to stop so you can relax, I will; if I am hurting you, tell me and I will stop."
- ☐ "I am going to use my hands to examine you, but they may feel funny because I am wearing gloves."

The physician's examination and diagnostic tests should be consistent with the nature of the assault as determined from the child's history, e.g., rape, molestation, oral or anal intercourse. Studies have shown that approximately 40 percent of all sexually abused children have positive findings on examination.[2] However, serious injury is rare: seven percent have vaginal or vaginoperineal tears; three percent require hospitalization, and the rest can be treated on an outpatient basis.[7]

In examining female children, most of the necessary information can be obtained through observation. The use of instruments usually is not necessary [3] and can be difficult without sedation or anesthesia, especially in prepubescent girls. Adolescents are usually more cooperative and better able to tolerate the use of the vaginal speculum. However, simple inspection can yield much information. To see the urethra, the hymen, and the vaginal canal, the examiner places his thumbs on the perineum beside the labia majora and moves them laterally down toward the floor. The physician can ask the child to help with the exam by holding her legs up and apart, or even by separating the labia with her fingertips. Areas to be noted are the perineum, labia majora and minora, introitus, vaginal canal, and hymen. Look for dried blood or secretions, edema, erythema, ecchymosis, petechiae, hematomas, abrasions, or lacerations. Note the nature of the introitus (whether it is stretched or enlarged), any pubertal changes, the presence or absence of a mucoid exudate in the vaginal vault, and the character of the hymen. One particularly lasting symptom, which may persist for hours after sexual penetration, is erythema at the fourchette or entrance of the vagina.[6]

Unfortunately, in evaluating sexually abused children, too much emphasis has been placed on the hymen. The presence or absence of the hymen neither proves nor disproves sexual abuse. The hymen can be ruptured by autostimulation and by trauma other than coital activity, such as falling from a bicycle. Penetration of the vagina may occur through a fimbriated, highly elastic hymen without producing a laceration. In addition, it is sometimes difficult to view the hymen due to the child's inability to cooperate. When examination is possible, the hymen should be described as: 1) present, intact, trauma-free; 2) present, intact, scarring; 3) recently ruptured; or 4) absent.[1] The examining physician should be aware of the possibility of serious injury, such as perforation of the vaginal mucosa or total avulsion of the vagina. Signs and symptoms of these injuries vary in intensity and may include difficulty in walking, severe bleeding, or mild ileus, crepitus or other evidence of intraperitoneal gas.[6] In such cases, a gynecologist or surgeon should be called.

In examining a male child, injury to the penis usually is observable. If trauma to the urethra has occurred, the urine should be examined for blood. In both male and female children, the anal region should be inspected if there is a history of sodomy. Look for bruises, inflammation, fissures, tears, and bleeding. Oral sodomy leaves little physical evidence, but throat cultures may be taken for lab studies.

Diagnostic tests are done for medical reasons, i.e., to determine the presence of venereal disease; and for legal reasons, i.e., to determine the presence of sperm or semen. These tests should be done on all areas involved in the assault: introitus or vagina, anus, penis, or mouth. Moist cotton-tipped swabs or eye droppers can be used to collect the specimens and to provide material for diagnostic tests. A smear and culture for Neisseria gonorrhea and a blood test for syphilis are routine. The initial blood test will not detect syphilis contracted from the assault, but will rule out the possibility of a pre-existing infection. To determine whether the disease was transmitted by the assault, a follow-up test must be done within eight to twelve weeks. Microscopic detection of sperm can be done from a dried smear or hanging drop preparation. Sperm remain motile for approximately three to six hours after emission,[5] but are detectable in a non-motile form for many days.[4] In female children, the presence of sperm, motile or not, is evidence of sexual activity. Vaginal secretions should also be tested for acid phosphatase content to determine the presence of semen. A concentration of acid phosphatase of 50 or more King-Armstrong units per ml. of vaginal aspirate is proof of recent sexual contact. Clothing also should be examined for secretions. Tests for semen deposits on clothing may be positive for as long as six months.[1] All specimens must be carefully labeled as they may be needed for legal evidence.

Although most studies show a low incidence of conception after rape, it is important to consider the possibility of pregnancy among adolescent assault victims. To determine the likelihood of pregnancy, it is necessary to obtain a complete menstrual history. When indicated, postcoital contraception, such as diethylstilbesterol, can be considered. This drug has a number of side effects, including nausea and vomiting. In addition, studies have shown that diethylstilbesterol, taken during the first trimester of pregnancy, can cause adenocarcinoma of the vagina in female offspring. The risks and side effects involved must be thoroughly discussed with the victim and her parents prior to administering the drug. It is also important to stress that failure to follow directions in taking the medication may result in pregnancy. If pregnancy does result, abortion may be considered as stipulated by law. In all cases of verified pregnancy, supportive services must be made continually available to the victim.

Following the physical examination, the doctor should answer the specific questions and concerns of the child. Simple, direct explanations usually are called for; in fact, providing too much detailed information may cause anxiety. The examiner will also want to meet with the family to explain the findings and any medical recommendations, and to answer any questions they may have. The primary concerns of most parents usually focus on whether or not their child has suffered lasting physical injury and whether the child, as an adult, will be able to have normal sexual relations and be able to bear or father children. This meeting also should be used to explain and arrange for needed follow-up services, which may include: a medical examination, if postponed initially; treatment, if necessary, for gonorrhea; a blood test for syphilis; and indicated medical care for injury. In addition, follow-up visits offer an opportunity to further assess and provide for the emotional needs of child and family.

Depending on the age of the child, the nature and circumstances of the assault, the identity of the offender, and the laws of the jurisdiction, cases of sexual abuse may involve civil as well as criminal offenses. It is important for health care personnel to be familiar with the relevant statutes in order to report these cases to the proper authorities. Whenever possible, parents should be informed before any report is made; children, if they are old enough to understand, also should be told of the report.

When such a report is filed, the physician usually will be asked to give an opinion as to whether or not sexual abuse has occurred. This can be a difficult decision. Frequently, there are minimal and inconclusive physical findings; at times, the exam is incomplete because the child was unable to cooperate; and often, the abuse occurred days or weeks before the exam. Physicians are not able, nor is it their responsibility, to determine who committed the offense. It is important to remember, however, that positive findings can be recorded without an interpretation of those findings and that state reporting laws require only that *suspected* abuse be reported.

In summary, crisis intervention techniques used throughout the initial contact with the child victim and his or her family are extraordinarily important. It is during this time that many of the fears and anxieties of the parents can be addressed; guilt can be alleviated; and concern for the child can be emphasized. Trained and sensitive professionals can provide the basic supports needed by parents and child to help them return to a normal life by integrating the sexual assault into their life experience with as little permanent damage as possible.

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# CHAPTER IV

# Venereal Disease in Children

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The word venereal comes from the Latin *venereus* or *venus*, meaning love or lust. The definition of venereal is "of or pertaining to sexual intercourse."[1] Thus, venereal diseases can be defined as diseases acquired through sexual intercourse. To be more accurate, venereal diseases are those acquired through intimate or direct contact with the infectious material or lesion, which is typically but not exclusively found on the genitalia.

Five diseases are classified as venereal: syphilis, gonorrhea, chancroid, granuloma iguinale, and lymphogranuloma venereum. There are nine other sexually transmitted diseases, including trichomoniasis and herpes simplex. Venereal diseases are caused by various types of organisms. For example, syphilis is caused by spirochetes, while gonorrhea and chancroid are caused by other bacteria. Certain viruses, protozoa, fungi, and parasites cause various other sexually transmitted diseases.[11]

Gonorrhea ranks first among all reportable communicable diseases in the United States. Strep infections and mumps rank second and third respectively; syphilis ranks fourth.[10] It is not surprising, then, that a major emphasis of our national public health effort is the treatment and containment of gonorrhea and syphilis.

Many physicians are aware of the possibility but uncomfortable with the reality that children may acquire gonorrhea through sexual contact. Often, infected children will be adequately diagnosed and treated; however, the source of their infection may not be questioned. When the source is not identified, the child remains at-risk for reinfection. Many lay people also are uncomfortable with this reality and prefer to believe that children can acquire venereal disease through contaminated bed or bath linens.

A few clinical studies of gonorrhea in children have attempted to determine whether children acquire the disease through sexual contact, and if so, in what percentage of the cases. Some studies, based on reviews of medical records of children with gonorrhea, have reported an "unknown" etiology for the infection in as many as one-third [5] [7] to two-thirds [8] of the cases. While these cases may be considered as acquired non-sexually, a more accurate assessment would be that the source of the infection simply has not been identified. As one author noted, the medical records of these children usually yield less pertinent historical data than are normally recorded in other diseases.[5] In 1965, Branch and Paxton published the results of their study based on interviews with gonorrhea-infected children and/or their families. In this study, 96 percent (43 of 45) of the children aged one through nine and 99 percent (114 of 115) of the children aged ten through fourteen were found to have a history of sexual exposure to someone infected with the disease. Through the careful interviews conducted by this physician and public health nurse team, the source of the infection was identified in all but one case.[2]

Having emphasized that venereal diseases in children are usually acquired through sexual contact, we must be aware that sexual contact may not be synonymous with sexual abuse. Not every child with a venereal disease acquired the infection from an adult or even from an older child. Many children may acquire gonorrhea from a playmate while engaging in normal sex play or sexual experimentation. Nevertheless, there is reason for concern when children's sex play allows an infection to spread through a neighborhood. Sometimes, a lack of supervision of children's play may be part of an overall pattern of parental neglect. In other cases, despite reasonable parental supervision, normal childhood curiosity and ingenuity succeed in giving the gonococcus an opportunity to spread.

Since venereal diseases are infectious, it is necessary to take the same medical precautions as would apply in the case of any communicable disease. Therefore, for example, when a child with gonorrhea presents for medical care, we are concerned to know where the child got the infection. Just as we ask a child with an infectious disease such as chicken pox, "Do any of your playmates have the chicken pox?", we ask a child with penile discharge, "Do any of your friends have the same problem?"

Both the parents and the child should be asked to identify other persons who may have come in contact with the infection. The family should be told about the need for contacts to be tested and treated—both to protect the community from further spread of the infection and to protect the individual from complications of the disease. It is important to use age-appropriate questions and vocabulary in interviewing children. Inquiries about games played with close friends or the activities of "naughty" playmates may elicit information unknown to the parents. Children usually respond best to a direct approach, such as: "This has made you feel kind of uncomfortable. Do you have any ideas about how you got sick like this?"

The majority of adolescent patients with venereal disease are simply sexually active, not sexually abused. Nevertheless, many adolescents are woefully ignorant about venereal disease and how it is acquired. Therefore, it is imperative that the professional assess the general knowledge level of the adolescent with regard to sexuality. Guidance, counseling, and outright education may be needed.

Gonorrhea and syphilis can pose subtle diagnostic problems requiring careful investigation. A better understanding of the nature of these diseases, their symptoms and treatment, is essential in serving sexually abused children.

As in adults, the most common site of gonorrhea infection in children older than one year is the genitalia—vaginal infection in females and urethral infection in males.[5] Nevertheless, there are two other sites of gonococcal infection—the rectum and pharynx. Gonococcal infection in the pharynx may appear as a sore throat and may indicate transmission by oral-genital contact. Rectal infection in the male probably reflects a rectal-genital and/or homosexual contact. In the female, rectal infection may be a result of rectal-genital contact, or it may indicate the spread of an infection from the vagina or cervix to the rectum. If indicated by the history, gonorrhea cultures of the rectum and the pharynx should be done at the same time as vaginal or urethral cultures.

Cases of conjunctivitis, caused by contamination of the eye with the organism of gonorrhea, usually occur early in the first year of life.[2] [5] In investigating the source of contamination, several possibilities may be considered. When a mother with gonorrhea gives birth, her infant may acquire the infection while passing through the birth canal. For this reason, all but three states have passed laws requiring that the eyes of all newborn infants be protected with an appropriate disinfectant. In most states, the law specifies the use of a one percent solution of silver nitrate, and this is the treatment of choice.[6] Conjunctivitis in infancy also may occur when an adult with gonorrhea unwittingly contaminates the eyes of a child.

The causative organism of gonorrhea is a gram-negative diplococcus called *Neisseria gonorrhoeae*. When stained with a special dye for bacterial cells, this organism is seen through a microscope as round, red, and occurring in pairs inside and outside of cells. It requires moisture and warmth for survival. In humans, the cells of the mucous membranes provide such an environment. Toilet seats and bed sheets do not.

The organism also prefers an alkaline pH environment, a significant factor in terms of the age-related symptoms of gonorrhea in females. In adolescent and adult women, the female hormone, estrogen, causes the cells of the vaginal lining to produce glycogen, a substance which is used by normal vaginal bacteria to produce an acid pH environment. Disease-producing bacteria cannot survive in this environment. As mentioned in Chapter II, estrogen production is low during infancy and childhood, and, therefore, the vaginal lining of the young girl is more susceptible to infection.[6]

The incubation period of genital gonorrhea ranges from one day to two weeks, averaging four days. The usual signs and symptoms depend on the age and sex of the patient and are briefly summarized in Table I. It is important to note that gon-

## TABLE I

### Symptoms of Gonorrhea

| | **Males (any Age)** | **Females (pre-pubertal)** | **Females (adult)** |
|---|---|---|---|
| **Incubation Period** | Average 3-5 days | Probably same as males | Probably same as males |
| **Symptoms** | • pain on urination<br>• penile swelling<br>• penile discharge<br>• inflammation of the head of the penis | • pain on urination<br>• vaginal discharge<br>• urethral inflammation<br>• lymph gland inflammation | • inflammation of urethra, cervix, glands of the genitalia |
| **Asymptomic Disease** | Occurs in 10% of males | Statistics specific to this group not available | Occurs in 75-90% of females |
| **Complications** | • fever<br>• rash<br>• arthritis | Usually none | • painful inflammation of tubes<br>• inflammation of uterus<br>• rash<br>• arthritis |

## TABLE II

### Symptoms of Syphilis

| | Primary | Secondary | Latent | Late |
|---|---|---|---|---|
| **Symptoms** | The primary stage is characterized by the chancre (an ulcer-like lesion) which may be seen on genitalia or mouth or rectum. The chancre is rarely seen in children. | If the chancre is untreated, the secondary stage occurs. Symptoms include fever, sore throat, rash, lymph gland swelling, and liver or kidney disease. | There are no latent stage symptoms | Late Stage symptoms can include neurological disease, cardio-vascular disease, benign tumors, blindness, and insanity. |
| **Duration of symptoms** | The primary stage symptoms appear 10-90 days after exposure, with an average incubation period of 21 days. The chancre may be persistent for 4-6 weeks. | Secondary stage symptoms may appear six weeks to six months after the chancre and last up to one year after the onset of the disease. | The latent stage begins after the secondary stage is resolved and may last for the life of the patient. | The re-emergence of symptoms marks the beginning of the late stage. |
| **Lab Tests** | Serologic tests will probably be negative. Darkfield examination should be positive. | In approximately 100% of cases, the serologic test will be positive. Darkfield examination of skin lesions will be positive. | Serologic tests will be positive. The absence of skin lesions precludes Darkfield examination. Spinal fluid will be normal. | Serologic tests will be positive. A spinal fluid examination may be positive. |
| **Communicability** | The chancre is highly infectious. | The lesions of this stage are highly infectious. | The patient is possibly infectious. The patient's blood is highly infectious. | The patient usually is not infectious after four years (except infection of a fetus by a diseased mother). |
| **Prognosis** | The patient can be successfully treated. | The patient can be successfully treated. | Treatment in successful in the early latent stage. | Treatment can ameliorate the effects of organic lesions caused by the disease. |
| **Risk of Infection** | The patient is vulnerable to reinfection from a subsequent exposure. | The patient remains vulnerable to reinfection from a subsequent exposure. | When treated in the early stage the patient may be vulnerable to reinfection from a subsequent exposure. | The patient probably is no longer vulnerable to reinfection. |
| **Destructive Organic Lesions** | No | No | No | Yes |

ococcal disease may be asymptomatic (i.e., present without any symptoms). This is probably more common among females than males and may occur in children, although little data is available.[4] The phenomenon of asymptomatic gonorrhea is of critical importance, since it is usually the presence of a symptom that causes people to seek medical care. An untreated, infected individual can be the unwitting instrument for spread of the disease. It is for this reason that all intimate contacts of a person diagnosed with gonorrhea should be cultured, whether or not they are symptom-free.

A preliminary diagnosis of gonorrhea can be made if, under microscopic examination, the causative organisms are visible in patient discharge material. To confirm that the organism is gonococcus and not something else similar in appearance, a culture will be necessary. Because of the fastidious growth requirements of the gonococcus, culture must be done with care on special culture media.[4]

Penicillin is the treatment of choice for this infection, but other antibiotics can be employed if the patient is allergic or the bacteria is resistant to penicillin. In cases where antibiotic resistance is a problem, careful follow-up is necessary to insure that the infection is eliminated and not merely retarded. Recommended treatment schedules for venereal diseases are available from local public health departments; the American Academy of Pediatrics; and the Venereal Disease Control Advisory Committee of the Center for Disease Control, U.S. Public Health Service.

The causative organism of syphilis is called *Treponema pallidum*. This organism, too, requires a moist, warm environment for survival. The disease, as it runs its course, is divided into four phases: primary, secondary, latent, and late. Characteristics of these phases are shown in Table II. Usually, the disease is transmitted by direct contact with the infectious lesions (chancre, rash, etc.) of primary, secondary, and early latent syphilis. When an untreated infection has persisted for more than four years, it is rarely communicable.[3]

A form of the disease not listed in the table but seen in children is congenital syphilis. This infection is acquired from the mother during gestation. An infant with congenital syphilis may have no manifestations at birth, and clinical evidence may appear only after several weeks or months of life. Usual findings include skin rash, fever, anemia, failure to gain weight, and restlessness. If bone inflammation occurs, the baby may have pseudoparalysis of the limbs; that is, the baby will not move an arm or leg because of pain from the disease in the bone.[8]

The appropriate laboratory tests to diagnose the disease depend on the stage of syphilis in the patient. The common "blood test" (VDRL) used to screen for syphilis examines the blood for a type of protein reaction. A positive test indicates that the patient may have syphilis. During the primary stage of the disease, however, blood tests probably will be negative, and even a positive test does not always mean that the patient is infected. For these reasons, further testing should be arranged at a designated public health clinic or hospital where the necessary and more sophisticated tests are routine. Depending on the stage of the disease, two forms of confirmatory testing are commonly used. One is the Darkfield examination, a special microscopic study to identify the organism, *Treponema pallidum*, in material taken from a suspected syphilitic lesion. The other is a more sophisticated blood test, the treponemal antigen test, which determines the presence of proteins that react specifically with the causative organism.[8]

Penicillin remains the treatment of choice for all forms of syphilis. In those cases when penicillin cannot be given, other antibiotics may be used. Because specific symptoms of the disease are transient, it is extremely important that the patient adhere closely to the prescribed treatment.

In summary, venereal diseases remain a significant public health problem among adults and increasingly among children. Often, the presence of a venereal disease in a child may indicate inappropriate sexual contact between the child and an adult. This possibility cannot be ignored. It must be considered and investigated by an appropriate agency.

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# CHAPTER V

# Sexual Abuse: The Reactions of Child and Family

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The sexual abuse or assault of a child can create a crisis for the entire family. The ways in which the child and family react to this crisis and the kind of professional intervention provided them during the crisis have important implications for the child's welfare—both immediate and long-term. Certainly, the child's age, emotional maturity, and capacity for intellectual understanding of the episode will greatly influence his or her reactions. Similarly, the reactions of parents will depend on their perceptions of and emotional responses to the incident. By gaining an understanding of the factors involved in these reactions, it is possible for the professional to anticipate and respond with sensitivity to the needs of all concerned.

We have found crisis intervention techniques to be especially useful in helping families cope with an incident of child sexual abuse. The crisis model enables us to provide immediate care and support in all cases of sexual abuse. It is particularly effective in cases of non-forcible or forcible assault by a stranger and in cases of non-forcible abuse by an offender known to the family when the parent's primary concern is the child and his or her needs. However, this therapeutic approach has the added advantage of providing both the time and the assessment tools to assist in determining the scope and nature of the service needs of families in cases involving incestuous relationships or other more severe intra-familial problems.

### The Child's Reaction

The ways children react to and cope with an experience with sexual abuse are closely related to a number of different variables. In addition to age and relative maturity, it is important to consider a child's emotional stability prior to the abusive incident, the nature of the incident, the relationship of the offender to the child, the parents' response to the child when the incident is disclosed, and the overall way in which the parents choose to handle the matter. Other factors which can play a significant role include hospital management of the child victim during the initial interview and physical examination and police investigation of the case. While it is obvious that these various considerations form a complex matrix, it is equally clear that many factors can be controlled for the benefit of the child.

Although there is little available information concerning the infant's response to sexual abuse, it is possible to draw some inferences from our knowledge of infancy in general. It appears that sexually assaulted infants become frightened and that this fear is not necessarily related to the sexual experience itself but rather to the general behavior of the assailant. Infants cannot understand the nature of the abusive incident; they perceive only that they are in the hands of someone who is not meeting their needs in the expected manner.[4] Forceful sexual assault may be perceived only as something painful and terrifying.

Infants who have undergone such an experience may display anxiety through excessive crying and generally fretful behavior. They may react with physical ailments, such as feeding or bowel disturbances, vomiting, or failure to thrive.

Like infants, very young children do not have the intellectual or emotional coping abilities to fully comprehend the significance of a sexual assault. In cases of forcible assault by a stranger, a toddler may understand only that he is faced with someone new and frightening and that he is being hurt. If his mother or primary caregiver is unable to respond to his cries for help, the child's sense of abandonment may intensify his fear and confusion.

By the time children are approximately three years old, their perceptions of the world have become more sophisticated. They may experience feelings of shame or guilt if these emotions are communicated to them by parents or other adults. Frequently, however, young children misinterpret the source of their parents' displeasure. For example, the parents of a sexually molested child may react with anger when they learn of the assault. While their anger is actually directed toward the offender, the child may come to feel that they are angry with her, especially if the assault occurred after she broke a family rule, such as playing outside her own yard or staying out after dark. Sometimes children find the sexual stimulation pleasurable; in such cases, guilt feelings may be even more pronounced.[4]

The difficulty encountered by young children in separating fact from fantasy is another factor which may influence their reactions to sexual assault. In fact, children may be more influenced by what they imagine occurred than by what actually occurred. For example, if a child imagines that the offending adult wanted to urinate on him, the incident may be remembered as unpleasant, but it may have no sexual connotations. When questioned about the experience, the child may report the event or his fantasies or both combined. He will consider all such answers equally "honest." Experience has shown that the child's first account of the incident usually is the most accurate. It appears that the more the child talks about the assault, the greater the possibility that fact will become mixed with fantasy. For this reason alone, it is best to keep the number of interviews for the child to a minimum.

The disclosure of a sexual assault is often closely related to the type of relationship the child had with the offender prior to the incident. When the offender is a stranger, for example, children usually tell their parents about the assault shortly after it occurs. When the offender is close to the family or a family member, there is often a lengthy delay in disclosure.

Young children are confronted with an especially difficult dilemma when the offender is someone well-known to them. Children are taught to respect and obey adults. They may be extremely confused when a known and trusted adult demands that they participate in activities which make them uncomfortable or seem "wrong." If these children rely on their training and experience, they may resolve the dilemma by doing exactly what they are told to do. Occasionally, adults misinterpret this acquiescence as willing consent.

If confusion, anxiety, or shame result from an incident of abuse, toddlers and preschoolers often manifest these feelings by regressing to earlier forms of behavior which may remind them of safer and more comfortable times. They may revert to thumb-sucking, baby talk, or bed-wetting; they may resume sleeping with a special toy that had been discarded some months before; or they may become afraid of the dark. Their behavior in general may become more fretful, whining, or clinging. Other changes in behavior may be related to circumstances surrounding the assault. For example, if the incident occurred at a neighborhood playground, the child may be afraid to return there. If the child was abused by a stranger, he or she may run to mother whenever an unknown person comes to the door.

Reactions to a sexual assault also may be reflected in a child's play activities, especially for preschool and elementary age children. There is no need for alarm if a child's normal sex play with toys or peers becomes more aggressive following an incident of sexual abuse. A child's play is his work. It is through play that children resolve conflicts and explore problems that are confusing for them. Adults, on the other hand, are able to talk out their problems. A person who has had major surgery may bend every available ear describing the pain, stitches, casts, and bandages. Because children do not have such sophisticated verbal skills, they must rely on more physical and concrete activities to help them work through their feelings.

Six-to-ten-year-old children are generally better able to separate fantasy from reality. These children usually can provide an accurate account of the incident that brought them to the hospital. They also have more avenues for channeling anxiety through talking and through play. For this reason, they may be better equipped to cope with an incident of sexual abuse. However, children in this age range have more social contacts through school and recreational activities, and therefore, are more susceptible to assault by persons outside their immediate circle of family and friends. Frequently, these children arrive in the emergency room because they have gonorrhea or a parent has witnessed their sex play with other children.

School-age children who have been sexually abused may also show some regression in their behavior. They may be terrified of a recurrence of the assault, have nightmares or other sleep disturbances, or experience school phobias. They may develop physical symptoms, such as abdominal pain, or have difficulty in urinating.[2] Frequently, the physical complaint is associated with the type of assault inflicted on the child (e.g., a sore throat in cases of oral sodomy; a stiff neck if the child was choked, etc.).

Adolescents may be particularly vulnerable to sexual assault as they are in the process of establishing their independence and assuming their sexual identity. At times, they may unwittingly encourage sexual exploitation by an adult. In some cases, a flirtatious teenager may provoke a sexual encounter beyond her expectations.

Forcible rape, a frightening and shocking experience for anyone, may be especially devastating to a teenager. The subjugation and humiliation attendant to such an assault can deliver a damaging blow to the adolescent's emerging sense of autonomy and self-sufficiency, especially if rape is the teenager's first experience with sexual intercourse. Adolescents' reactions to rape often parallel those of adults, though their dependency needs may be somewhat greater. They may feel grief over the loss of virginity, pronounced fear of a recurrence of the attack, anger over being forced into a situation beyond their control, and degradation and depression over such an invasion of their persons. A violent rape may cause the victim to fear further sexual encounters of any kind. In cases of homosexual assault, the adolescent's normal sex-related fears and conflicts may be intensified.

Adolescents who become involved in long-term sexual relationships with adults may have particularly severe problems when the relationship is discovered. They often have little self-esteem and feel rejected or betrayed. If their anger is directed inward, it may lead to serious long-term problems including suicidal thoughts or gestures or drug or alcohol abuse. They may run away, become involved in an early marriage, or become promiscuous. Promiscuity, like sex play in childhood, may represent the teenager's attempt to resolve conflicts concerning sexuality and relationships with others.

### The Family's Reactions

The parents' reaction is probably the greatest single prognostic indicator of the emotional effects of an incident of sexual abuse on a child. As described by De Francis in a 1969 study of sexually abused children in New York City, initial parental reactions can be divided into three categories: child-oriented, self-oriented, and offender-oriented.[3]

When the parents' response is primarily child-oriented, the child usually has a better chance of recovering from the assault within a minimal period of time. Child-oriented responses are most common in families where the child was forcibly assaulted by a stranger or by someone known to the family but not part of the primary family system. In this type of response, parents express strong concern for their child. They usually are shocked that anyone would approach their child sexually and often are frustrated or angry when findings from the physical examination are not sufficient to prove or disprove sexual abuse. Usually, these parents are receptive to police investigation. Involving the authorities may help relieve their feelings of helplessness while providing an appropriate way to channel their anger against the offender. It is important to note, however, that the needs of the child can become obscured when parents are preoccupied with a dogged or vengeful pursuit of the offender.

Some self-oriented responses are natural for all parents. When their child is threatened or injured, most parents feel some guilt or inadequacy for having failed to provide sufficient protection. If, as a child, the parent was subjected to a sexual assault, the new incident of abuse may awaken painful memories, making it difficult for the mother or father to focus on the needs of the child. There is particular reason for concern in such cases when the parent's unresolved conflicts are projected onto the child.

Offender-oriented reactions can be divided into two categories of response: aggressive or protective. Frequently, parents who have real concern for the safety of their child will want the offender identified immediately and apprehended by the authorities. If the offender is known to the family, an angry parent may want to conduct his own search with the aim of getting revenge. In the second type of offender-oriented response, the parent wants to protect the offender from the authorities. Usually, the offender in these cases is someone close to the family, a family member, a step-parent, or a boyfriend. Particular concern is warranted in such cases when, in the face of convincing evidence to the contrary, a parent persistently denies the possibility of abuse and focuses his or her anger on the child. For example, in one recent case, an eight-year-old girl was found to have gonorrhea and claimed that she had been sexually molested by her mother's boyfriend. Her mother refused to consider this possibility and insisted that the child was lying. In this situation, which is similar to incest, the mother's reluctance to accept the child's explanation and address her needs may stem from very real fears of losing her boyfriend. The threat of such personal emotional and/or economic loss may be intolerable to her and may override her concern for her daughter. Her reluctance may increase if she perceives that her daughter was a willing participant in the incident, and she may reject the child's story out of anger or even jealousy. If she continues to associate with her boyfriend, the child may be in danger of further sexual exploitation. For this reason alone, it is important to assess carefully the parent's reactions to the child and the offender.

### Crisis Intervention with Child and Family

In many cases, sexual abuse can be viewed as a situational crisis for the child and family; in such cases, the treatment goal is the resolution of feelings about the abusive episode so that all family members can return to normal functioning as soon as possible. In other cases, such as those in which the offender is a parent or parent figure or the abuse has been occurring over a period of time, crisis intervention techniques may be used to help family members cope with their immediate reactions and to ease the transition to a more intensive therapeutic intervention.

In crisis intervention for situational sexual abuse, when treatment is initiated close to the time of the precipitating event, the therapist's role is active and direct. Some of the techniques used include: helping the family gain an intellectual understanding of the event; assisting them in bringing their feelings into the open; exploring past and present coping mechanisms; finding and using situational supports; and anticipatory planning to reduce further trauma for the child and to protect the child from a recurrence of the abuse.[4]

Since children are often most affected by parental reactions to the assault, [4] intervening with parents of young children can be an effective way to offer services to the whole family. As discussed in Chapter III, when interviewing parents about the sexual assault, a skilled worker offers reassurance, guidance, and support to help them place the incident into more reasonable perspective. Parents are encouraged to return to normal living as soon as possible, to offer the child special understanding and support, and to respect the child's privacy about the event. Ways of protecting the child from re-abuse also are discussed. Describing the typical reactions of children to sexual abuse prepares parents for any behavioral changes that might occur. Such explanations also permit a parent, who may be feeling helpless or inadequate, to gain some sense of control over the situation.

Specific suggestions to parents about intervention with their child would again depend on the child's age and maturity. The parents of an infant could be encouraged to reduce the number of strangers who come in contact with the child and to spend more time holding and cuddling him or her. In fact, all parents should be told of the need to offer their children physical affection, as there is often some reluctance or discomfort about hugging or holding a sexually abused child.

Parents of toddlers or preschoolers may find it difficult to understand that their children do not perceive the assault in the same way as an adult would. This is true regardless of the identity of the offender. It is important that parents take care and are helped not to project their own interpretations of the event onto their children. Parental reactions of shock or horror may be perceived by a child as implying some personal criticism. While children's questions about the incident or other sex-related matters should be answered honestly and calmly, it is not necessary or useful to explain all facets and details of sexual relationships. Too much information may be as confusing to a young child as too little. Frightened children need to be reassured that they are safe and loved.

As previously mentioned, preschool and school-age children may engage in some form of aggressive sex play following an incident of sexual abuse. Parents need to be forewarned that this type of behavior is normal and not an indication of serious sexual problems or incipient promiscuity. In such cases, parents can explain to their children that it is preferable to draw pictures or play with dolls and toys rather than with peers. Although some children prefer to keep the abusive incident to themselves and may even resist discussing it, others want or need to talk through their feelings and conflicts. While discussion should be encouraged, parents can explain that it is best to keep such conversations within the family. If a school-age child begins to experience some difficulty in school or other regular activities, it may be an indication of anxiety. By creating an open atmosphere where the child can talk about his feelings and concerns, parents can help alleviate much of this apprehension.

Sexually abused adolescents may require special support and consideration. Because of their growing sense of autonomy and independence, they may be particularly reluctant to confide in their parents. In times of crisis, teenagers tend to rely more on peer support than on parental guidance. However, they still need the reassurance of parental concern and acceptance. Parents can best help their teenage children by avoiding a tendency to be over-protective, by keeping lines of communication open, and by ensuring that the child has ready access to some other trusted person or professional counselor if parental support is shunned or insufficient.

Following the initial emergency room contact with parents and child, any additional intervention services must be planned according to the family's needs. Depending on the type of assault and the identity of the offender, a family with adequate social supports may not need long-term follow-up. However, at least one home or office visit is recommended to reinforce parental support for the child and to help parents work through their own emotional conflicts related to the abuse. If the offender was someone known to the family, parents frequently need ongoing help in resolving their offender-oriented anger or disappointment. If the child is to be involved with the law enforcement system, the worker should explain the legal process to the family and may provide emotional support by accompanying them to the various proceedings.

Follow-up interviews with the parents also can help the worker reassess the child's reaction to the assault. If, after six to eight weeks, the child continues to have difficulty in sleeping, eating, play, or school activities, further intervention services are indicated. These difficulties may stem from pre-existing emotional problems in parent or child and require more extensive professional evaluation and treatment.

During the follow-up period, the worker may identify a variety of family problems which are unrelated to the incident of sexual abuse. If these problems are related to the child's health and development, a referral to a public health nurse can be useful. When families are found to have multiple social, financial, and medical problems, it may be necessary to refer cases to an experienced social worker who can coordinate a range of supportive services.

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# CHAPTER VI

# Incest: A Review of the Literature

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Incest remains the most emotionally charged and socially intolerable form of sexual abuse, the most difficult to understand and accept. As in all forms of child abuse, an understanding of the people involved and the dynamics of the incest relationship will improve our ability to work with these children and their families. Unfortunately, incest, by its very nature, tends to remain a family secret. Therefore, it is difficult to make generalizations about its etiology, effects, and treatment. Most articles that treat the subject in depth are based on small numbers of cases.

In most areas of the country, a diagnosis of incest is still a sure guarantee that the family will be disrupted. Nevertheless, we are learning that these families can be treated and treated successfully. In 1971, a treatment program for incestuous families was established in Santa Clara, California, under the supervision of Dr. Henry Giarretto. By July 1976, the program had treated 400 families in which incest occurred. Of the families that received a minimum of ten hours of treatment, 95 percent have been reunited with no reports of recidivism.[11] Unfortunately, such programs remain largely unavailable in the country today.

Incest is considered to be a universal taboo, a taboo that has been explained as deriving from an innate biological mandate against inbreeding,[18 28] and as a social measure designed to maintain the integrity of the family unit,[16 29 36] avoid role strain and role confusion among family members,[8 16 43] and eliminate disruptive and competitive family rivalries.[11 16 25 30] Since ancient times, incest has been prohibited in most societies. The taboo was originally enforced by the tribe and later by the church. Today it is enforced through the courts as well. In law, incest is defined as sexual intercourse between persons who are too closely related to legally marry.[35] While laws vary from jurisdiction to jurisdiction, marriage usually is prohibited between blood relatives closer than first cousins.

The actual incidence of incest is not known. Reporting is low for many reasons: the taboo, fear of societal reactions or family disruption, lack of available help, guilt feelings of the participants, and the reality of criminal punishment. Some studies, however, do shed light on this phenomenon by examining the cases of incest that are reported. In the classic incidence study, published by Weinberg in 1955, the yearly average rate of reported incest in the United States was computed to be 1.9 cases per million population.[36] In contrast, the Children's Division of the American Humane Association estimated in 1969 that at least 5,000 cases of incest occur nationally each year, a comparative rate of 40 cases per one million population.[30] The Santa Clara program, which has a service area comprising only slightly more than one million people, now receives almost 200 referrals annually.[11]

The relative frequency of convictions for incest among all adult males incarcerated for sex crimes is low. One study of 250 sex offenders found that 4 percent had been convicted of incest.[1] Other estimates range from 2.4 to 6 percent.[13] However, when examining cases of sex offenses involving children, studies indicate that some form of incest probably accounts for at least one quarter [20] to as much as one half [5] of all cases.

Incestuous experiences are described according to the blood relationship of victim to offender. Reviews of court records or cases known to the socio-legal system usually reflect a high proportion of cases involving fathers and daughters. For example, Weinberg found that 78 percent of 203 incest cases reported to the courts in Illinois involved a father and daughter.[36] However, the types of cases reported may or may not reflect actual incidence rates. It is possible that other forms of incest occur as frequently or more frequently but are less likely to be reported.[37] In a 1976 study of the family histories of 237 drug abusers, 38 of the males (out of a total of 152) and 32 of the females (out of a total of 85) reported a childhood experience with incest. Although conducted with a special population, this study is of particular interest for the information it provides about the frequency of various types of incest. Among the men studied, 49 percent named a female cousin as their partner in the incestuous relationship. Other partners included sisters (21 percent), brothers (11 percent), and male cousins (5 percent). In all, the men reported incest experiences with age peers in 91 percent of the cases. The distribution for females was quite different. In 55 percent of the cases, women reported incest experiences with cross-generational partners. These included stepfathers (16 percent), uncles (11 percent), natural fathers (9 percent), and grandfathers (9 percent). Partners of the same generation included brothers (16 percent) and male cousins (11 percent).[34]

Although research data is lacking, sexual contact between brother and sister is believed by some to be the most common form of incest.[37] By definition, sibling incest involves more intimate behavior than is usually permitted as part of normal child sex play and experimentation. Nevertheless, such relationships are thought to be transient and may be relatively free from damaging psychological sequelae.[37] There are some indications that adolescent sibling incest may be more frequent if the children involved have not indulged in normal preadolescent sex play.[27] Sexual relations between cousins are considered to be similar to brother/sister incest in dynamics and effect, except when the relationship is cross-generational. If there is a large age discrepancy between cousins, the chances of psychological damage increase.[34]

Mother/son incest is believed to be rare; the taboo against the relationship is strong, perhaps stronger than for any other form of incest. It is believed to occur when there is strong psychopathology in one or both of the participants.[4] [27] Factors which may contribute to the formation of this relationship include: an absence of the mother during the child's formative years; relatively little age discrepancy between mother and son; alcoholism; the lack of other sexual objects available to the son; and a general history of incest in the family.[33] Case reports indicate serious psychological sequelae, such as homosexuality [4] or schizophrenia of the child.[4] [33]

Incest between father and son also is thought to be uncommon. In these relationships, the father's usual behavior toward his son may be aggressive, infantilizing, and controlling; eventually, this behavior may find expression in a sexual mode.[15] It also has been suggested that the primary stimulus for father/son incest may be the father's own unresolved adolescent sexual conflicts.[4] In the few existing case studies, there is conflicting evidence about whether or not father/son incest results in homosexual behavior or a preoccupation with homosexuality among boy victims.[4] [15] The actual impact of father/son incest is not known due to the scarcity of reported cases.

Mother/daughter incest is thought to be very rare, though it may occur on a more subtle level. For example, there have been some case reports of schizophrenic women who were adversely affected by homosexually-toned relationships with their mothers.[17]

Another form of incest, sometimes referred to as the Phaedra complex, occurs between stepchild and stepparent, usually stepdaughter and stepfather. The incest taboo is diluted in these relationships, and they usually are not viewed with as much social censure as incest between blood relations. The psychological consequences for the child depend greatly on the degree to which the stepfather has assumed the true fathering role. It has been suggested that measures aimed at strengthening the family unit (and the taboo) can be useful in preventing this type of incest. For example, reinforcement of the mother/father and husband/wife roles is recommended, as is enhancing the fathering role of the stepfather through legal adoption.[23]

Father/daughter incest is the type most commonly reported to authorities. Perhaps for this reason, it also is the type most commonly studied and about which most is known. When this relationship occurs, it is usually a symptom of general dysfunction within the family. In one sense, father/daughter incest can be seen as an abnormal resolution of a normal developmental process in which the child's romantic attachment to the opposite sexed parent is inappropriately gratified. For a broader understanding of this phenomenon, however, it can be characterized as a pathological paradox involving the entire family, i.e., the poorly functioning family may use incest to maintain itself, thus violating the very taboo that exists to preserve the family unit. It has been found that members of such families have very real fears of deprivation and desertion. To prevent the realization of these fears and in a desperate attempt to remain together, the entire family may become involved in what might be called an incestuous triangle. The sexual needs of the father are met within the family, not by the mother, but by the daughter. Thus, using pathological logic, the father remains within the home, and the family unit is preserved.[13] [14] [19]

Weinberg has divided fathers who commit incest into three personality categories: 1) veering toward psychopathy with indiscriminate promiscuity; 2) socially immature and psychosexually retarded with a pedophilic orientation (i.e., involved with his own and other children); and 3) introversive with an extreme intra-familial orientation.[36] It is the last type that probably accounts for the majority of incest cases. Reported characteristics of fathers who commit incest include an emotionally deprived childhood and chaotic family life,[6] [14] [19] [37] an extreme emotional dependence on their wives,[22] and a nonaggressive and ineffectual personality with poor impulse control.[14] [26] In addition, they often have an immature sexual orientation and poor sexual adjustment.[27] [37] Although some are poor providers with a history of frequent separations from the family,[14] others are socially well-adjusted and appear to be good fathers and husbands.[11] Many have been found to have a history of alcoholism.[14] [32] Studies have shown that most of the fathers are in their thirties or early forties when the incestuous relationship begins.[27] [30] For many men, increased marital stresses occur at this time, and there is often a pubescent daughter present in the home.[7] Their sexual overtures toward their daughters may be rationalized as expressions of love or as part of their responsibility to be both the child's protector and her initiator into sexual experiences.[7] [27]

It is often the mother who provides the key to the father/daughter incest relationship. Reports of psychiatric case studies indicate that father/daughter incest sometimes involves at least unconscious participation and/or sanction by the mother.[14] [19] [21] The mother in such a family usually has experienced physical or psychological desertion during childhood; as a result, she often has strong residual dependency needs. Because of her early experiences of maternal deprivation, however, she may feel great hostility toward her own mother. Her poor concept of mothering and her own need to be mothered may cause her to cast her daughter in the maternal role. She may become both hostile toward and dependent on her daughter.[14] [19] In addition, the mother usually fears any close relationship and is frequently sexually rejecting of her husband.[13] [19] Eventually, this role reversal of mother and daughter may place the daughter in a position where she is called upon to meet the sexual needs of the father.

Although it is believed that in many cases the mother knows consciously or unconsciously of the sexual relationship, few of the reports of incest are made by the mother.[11, 14, 32, 36]

The child victim of incest is usually the oldest daughter.[13, 19, 36] However, case studies indicate that the relative sexual maturity of the daughter does not contribute significantly to the occurrence of incest.[14, 19] Giarretto reports that the average age of the daughter is ten years when her father begins his sexual advances.[11] Although often sexually immature, the daughters usually exhibit pseudo-maturity and are often caretakers of the home and younger children.[19] They often assume this role at an early age because of the disrupted state of the family unit.[19] The child may fear her mother and receive little affection from her. Prior to the actual incestuous relationship, the child may exhibit coy or flirtatious behavior toward her father. This behavior is not intended to obtain sexual gratification, but instead, is an attempt to secure the affection she is denied by her mother.[5, 12, 19, 26]

The daughter's affection-seeking behavior, combined with her fear of family disruption and her sense of maternal responsibility, allows the child eventually to become involved in a physically close, giving and receiving relationship with her father. This relationship may evolve gradually, with the daughter assuming a passive role and offering no physical resistance to her father's increasingly aggressive sexual advances.[21, 36, 37] Sexual intercourse between the two may be the pathological result of this increasingly intimate contact.

The incestuous relationship may continue for years [14, 19, 21, 37] and, in some cases, may be inherited by the next youngest daughter when her older sister leaves home.[36] Abrupt disruption of the incest pattern may never occur. However, in some cases, the child, after achieving some degree of social and sexual awareness, leaves home, seeks help for herself,[7, 24] or requests protection for her younger sisters. At times, the relationship comes to the attention of authorities when the girl becomes pregnant. Occasionally, a history of incest is obtained from a runaway who refuses to return home or from a child who has made a suicidal gesture. Complaints from other family members may terminate the incest, though such complaints are sometimes motivated by anger over some unrelated matter.[36]

The accusation of incest against a family may awaken painful guilt feelings, associated with denial and depression.[7] If the mother has been aware of the situation, she may deny any knowledge of the matter, accusing her daughter of lying. Her inadequacies as a wife and mother are exposed, and she fears the disintegration of her family and the loss of her husband.[19, 37] The father's guilt, shame, and fear of repercussions may be overwhelming, and he may totally deny his daughter's allegations.[7] Thus, the child may be rejected by both parents, perceived as guilty, and seen as a betrayer of her family. Under these circumstances, many children will retract their stories. Since incest is often a well organized family survival pattern, it is only after the incest is discovered that the greater family problems and needs may surface.[19]

Anxiety and guilt, depression and disgrace, may be felt by everyone involved, yet most studies have focused on the child's reactions. The effects of incest on the daughter vary and depend on her age, her level of functioning prior to the relationship, and her experiences in the social and legal systems after disclosure. Preadolescent girls may be less affected by an incestuous relationship than older girls,[31, 37] perhaps because young children do not have such firm concepts of right and wrong and lack awareness of the possible social repercussions. Some case studies indicate that adolescent children may be relatively unaffected if they were well-adjusted prior to the experience,[29] and if both parents display little guilt or anxiety when the incestuous relationship is discovered.[2]

Other studies show that incest can result in serious confusion for the child over her sexual identity and may lead her to fear her own sexuality.[14] She may appear as a "sold-out" personality, her childhood needs having been sacrificed to what her parents perceived as their own greater needs.[9] These girls may exhibit learning difficulties or somatic complaints; they may become runaways, attempt suicide, or become sexually promiscuous.[14, 24] Some authors report that the daughter's feelings of guilt, depression, and anxiety appear to be more closely related to the break-up of the home following disclosure than to the incest experience itself.[14] The available research is inconclusive as to the nature and degree of the impact and the long-term traumatic effects of incest. Nevertheless, the potential for damage appears so great that the children and families involved in incestuous relationships must be seen as in need of immediate help.

In the treatment of incest, it is important to focus on the family dynamics [7, 21] and to consider the incestuous relationship as a symptom of a family dysfunction.[11] The goals of therapy should be to alleviate the emotional impact of the crisis after discovery, to foster a sense of self-worth and self-management, and to re-instill a feeling of unity in the family.[10, 11] The roles of family members must be restructured with emphasis on individual identities and responsibilities and extra-familial relationships.[21]

The immediate emotional impact can be lessened by effective crisis intervention techniques. The worker should know the importance of ventilation, the need to decrease the parental guilt and anxiety communicated to the child, and how to maintain a non-accusatory, non-judgmental attitude. It is believed by some that recurrence of incest after disclosure is unlikely,[7] but therapeutic emphasis must be placed on the importance of discontinuing this behavior. It is also critical to focus on the elimination of denial, for if denial persists, pathological relationships are unlikely to change.[21] If the intervention consists solely of removing the father from the home, there is some evidence that the incestuous relationship may be resumed when he returns.[27, 30]

Identification and treatment of incestuous families also can serve as a preventive measure. There is some evidence that incest may be passed from generation to generation. This "incest carrier" concept is supported by case histories showing that mothers and fathers who involve their children in incestuous relationships often were themselves victims of incest as children.[4, 26]

Other children in the family also may need professional attention.[7] Siblings may have intense conflicts over the incestuous relationship between their sister and father which can result in long-term emotional problems.[9]

Separating the family through imprisonment of the father or outside placement of the child does not constitute adequate treatment in and of itself. Even with legal intervention, many of these families will be reunited. In a 1971 British study, Williams found that less than 50 percent of over 300 incest complaints resulted in conviction. Of those convicted, only 57 percent were imprisoned, and a large proportion of the sentences were for three to four years.[38] Eventually, these fathers may return home.

Families in which incest occurs require long-term support by social and legal agencies. These supportive services must be made available, for they can make a difference in the lives of all family members, and, in many cases, allow the family to again function as a healthy unit.

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# CHAPTER VII

# The Nature and Treatment of Male Sex Offenders

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In working with sexually abused children, some understanding of the offender and his typical behaviors can assist greatly in assessing the impact of the abusive experience on the child or adolescent victim. In addition, when the identity of the offender is known, an understanding of his sexual orientation can assist in forming recommendations for treatment and/or imprisonment, thereby reducing the risk to others. The purpose of this discussion, then, is to provide a general framework for understanding offensive sexual behaviors as they relate to children. Because most of these acts are committed by males, either adults or adolescents, the discussion is confined to male offenders.

Offenses against children and adolescents occur both in circumstances where the offender's behavior is an expression of abnormal sexual preferences (i.e., the offender prefers sexual activity with a child) and in situations where normal, preferred sexual outlets are thwarted (i.e., the offender would prefer a more appropriate sexual partner but perceives that none is available). In clinical terms, the former behavior is seen as deviant, while the latter is considered non-deviant. It is important to determine whether a deviation exists on the part of any offender, for the presence of a deviation suggests an habitual, enduring pattern of behavior. Such determinations often can be made with a high degree of accuracy by evaluators with clinical experience in this field.

All persons, non-deviant or deviant, seek sexual outlets which reflect their preferences with regard to the age and sex of a partner and the type of activity desired with the partner. The majority of adults prefer an adult partner of the opposite sex; the preferred activity is intercourse. However, if conditions curtail the availability of the preferred partner or activity, some persons may seek sexual outlets which differ from the norm. For example, a man in prison may submit to homosexual advances, though he would prefer a female sexual partner if one were available. For non-deviant individuals, the pre-existing, normal sexual preferences will reassert themselves once the limitations are no longer present.

Deviant preferences regarding sex partners may involve both the age and the sex of the preferred partners. Deviant preferences with regard to the type of activity desired with the partner fall into three categories of behavior: non-genital, non-aggressive genital, and aggressive genital. In the non-genital category, exhibitionism is the major reported offense against children and teens, with voyeurism a distant second. Offenses in the second category, non-aggressive genital offenses, are distinguished by the active attempt on the part of the offender to entice or seduce the child into both a sexual and emotional relationship. Often, the offender has a strong emotional attachment to the child and desires to maintain a continuing relationship. Aggressive genital offenses, those in the third category, are distinguished by the offender's disregard for the wishes of the victim; attempts to gain consent or cooperation are perfunctory or absent. Offenses in this category range from rape to the most dangerous, but fortunately rare, acts of sexual sadism.

Given these dimensions of preferred age, sex, and activity, it is possible to review briefly the types of offenders who select child and adolescent victims, their typical behaviors, the impact of these behaviors on their victims, and the implications for treatment.

Offenders classified as non-deviant are those men whose preferred sexual partners and activities fall within a range accepted as normal. When such men choose a female child or adolescent as a sex partner, it is usually an indication that access to age-appropriate, preferred partners is limited, that an acquiescent minor is available, or that social mores and poor impulse control fail to inhibit such behavior. Father/daughter incest is the best studied example of this phenomenon. As discussed elsewhere, such relationships often reflect family dysfunction rather than true sexual psychopathology on the part of the offending father. Family therapy in such cases has been found to be successful and is often the treatment of choice. The literature suggests that recidivism is quite low when adequate family therapy is provided. In situations of physical crowding and social disorganization, sexual liberties between unrelated adults and children, and adolescents and children, may occur with considerable frequency. It is not known whether the dynamics of such situations parallel incest.

Juvenile offenders, i.e., adolescents who commit sex offenses against other children, are particularly difficult to categorize. For the most part, it is likely that their offenses indicate a retardation in psycho-sexual development; they simply may not have progressed beyond childhood sexual play and exploration. In some cases, however, the offensive behavior could be an early manifestation of pedophilic or aggressive sexual preferences, and as such might be considered deviant. Frequently, adolescent offenders are socially isolated and have parents who minimize the seriousness of their acts. When the boy's behavior is non-aggressive, experience indicates that he and his family can be treated successfully on an outpatient basis.

Among offenders exhibiting deviant behavior, exhibitionists are generally considered to have the least damaging impact on their victims. The interaction sought by the offender is non-genital and is limited to the exhibitionistic act. Typically, exhibitionists do not progress to more active or violent offenses. Because of popular misconceptions to the contrary, however, the victim or the parents may fear that he will do so. The act itself is compulsive and often employed self-destructively with little regard to possible consequences. Offenders are usually young adult men at periods of life stress. Often, they function normally in adult heterosexual relations. Although recidivism is quite high, psychotherapy directed toward resolving the underlying dynamics of the self-destructive and exhibitionistic behavior often can be successful.

Deviant non-aggressive genital preferences are typified by pedophilic offenders. These offenders, by definition, prefer sexual activity with prepubescent children. Their sexual orientation may be either heterosexual or homosexual; a bisexual orientation is unusual. The behavior is non-aggressive, with an attempt actively to seduce and maintain a relationship with the child. The activity may include fondling, oral-genital contact, or simulated intercourse between the thighs or in the groin area. Penetration is uncommon, especially with young children. These men often possess great sensitivity and compassion for children; their regard for children and their ability to court them with success may lessen somewhat the impact of their sexual exploitation. Their intrinsic preference for child partners is quite resistant to lasting therapeutic intervention via traditional psychotherapy or behavior modification techniques. When the goal is sublimation and impulse control, or impulse suppression through medical treatment to decrease the sex drive, treatment has met with greater success. Recidivism is moderate, and somewhat greater in the homosexual than the heterosexual group.

Hebephilic offenders (those who prefer adolescent girls) and ephebophilic offenders (those with a homosexual preference for adolescent boys) exhibit characteristics which parallel those of the pedophile. However, the activity desired more closely resembles that sought by heterosexual and homosexual persons with adult partners. Therapy with the goal of reorienting these offenders toward adult partners is more successful, and the rate of recidivism is lower than with the pedophilic group.

Aggressive genital offenses take the form of rape or sexual sadism. The sexually deviant men who commit these acts present particularly difficult problems both in terms of the physical and emotional trauma they inflict on their victims and in terms of treatment for the offender and prevention of further sexually-motivated assault.

As previously noted, rape is characterized by a disregard for the victim's wishes and an absence of seductive or courting behavior. The rapist's orientation is usually heterosexual; repeated contact with the victim is not sought. Aggressive behavior is common, as are attempts at penetration, sometimes accompanied by physical injury. Rape which involves perverse humiliation of the victim or forced oral or anal penetration may inflict considerable physical and emotional trauma. Such incidents demand follow-up professional attention for both the victim and the family. Long-term incarceration, with psychotherapy directed toward impulse control and the learning of appropriate social and sexual behaviors toward adult partners has been successful with a small proportion of these offenders. Medical treatment to decrease the sex drive also has been employed in some cases.

Sexual sadists are rare but exceedingly dangerous. Injury or murder are intrinsic parts of their pattern of sexual gratification. These offenders may be either heterosexual or homosexual in orientation. When a sexual offense involves a fascination with blood or manipulation of the neck of the victim, authorities should consider the possibility of an underlying sadistic deviation. With the exception of medical treatment to reduce libido, no currently available treatment methods have proven successful with these offenders. Needless to say, encounters with these men are extremely traumatic to a child or teen and demand professional follow-up.

With all offenders, it is essential to explore the role of alcohol in the commission of the offense. Treatment of the deviation is likely to be unsuccessful if alcoholism, as a contributing factor to the loss of impulse control, goes untreated. Success in the treatment of offenders also is enhanced if the individual is able to accept the need for treatment and if he enjoys the social supports of family and work. Community supervision by an involved, available worker following a course of institutional treatment and the deterrent influence of possible reincarceration are both cited as important factors in successful rehabilitation.

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# CHAPTER VIII

# Sexual Acts Against Children: Medical-Legal Aspects

Karen M. Leaman, R.N., M.S.N. in consultation with Nan R. Huhn, J.D.

The sexual abuse or assault of a child is a crime. Those who work with child victims and their families cannot ignore the impact of the legal system. Because laws concerning sexual acts against children vary from jurisdiction to jurisdiction throughout the country, this chapter cannot begin to cover all the provisions and ramifications of specific laws as they apply to the offender, the child, and the family. We can only stress the need for physicians, nurses, social workers, police officers, and all other helping persons who work with children to be thoroughly familiar with their obligations under the laws of their own jurisdictions. The purpose of this chapter is to draw some inferences about laws dealing with sexual offenses against children and to consider some implications of these laws for the children they are designed to protect.

In most jurisdictions, health professionals are required to report cases in which sexual assault or abuse is suspected. These cases are then investigated by the police and/or a protective service agency. Within this context, it is the responsibility of the police to gather evidence that will lead to the identification, apprehension, and conviction of the offender, and it is the responsibility of the police or a protective service agency to gather evidence that will permit a court determination as to the degree of risk to which the child is exposed in his or her home. To aid them in their work, the investigating agency or agencies request assistance from health personnel which includes: immediate notification on cases in which sexual assault or abuse is suspected; immediate, thorough physical examination of the child; photographs of injuries; copies of the appropriate medical-legal form(s); and results of laboratory tests as soon as possible. Certainly, these requests are valid. Unfortunately, they are often difficult to fulfill.

It is not always possible to provide the police with immediate notification. The physician may not even suspect sexual abuse until the interview, physical examination, and laboratory tests are completed. Even then, the offense may have occurred several days or weeks earlier. Medical reports and laboratory findings are often inconclusive. Because most children are not forcibly assaulted, it is the exception rather than the rule to find physical injuries which could be documented with photographs.

Misunderstandings between police and health professionals over their respective roles and capabilities can pose serious problems in communication and cooperation in cases of child sexual abuse. One major problem lies in the nature of the law itself, which requires clear evidence that is often unobtainable in these cases. While there can be no doubt about reporting violent offenses, decisions in other cases are not so clearcut. For example, when a twelve-year-old girl is forcibly raped by a stranger and immediately rushed to the emergency room, there is obvious evidence of assault. This may include torn clothing, bruising, hymenal tears, bleeding, and other marks of violence. In this situation, the physician's decision to report the incident is clear, and the police have both the physical evidence they require and the additional assistance of the child's testimony to help them in apprehending the offender and bringing him to trial. Given adequate support, the child may be mature enough to withstand questioning by police officers, lawyers, and the judge, if necessary. In such a case, health care and legal institutions can work together smoothly and effectively to protect the child and the community.

In other cases, the process is more complicated. Most sexual acts against children, especially the very young, are nonforcible; the offender is often a neighbor, friend, or relative. It is in these cases that misunderstandings can and do arise between health professionals and the police. For example, a four-year-old child may be brought to the emergency room because she has been scratching her vagina and has a thick, yellow vaginal discharge. During the interview, the child seems unable to understand the questions asked by the physician. The physical examination and laboratory tests show that the child has a reddened, somewhat swollen vagina and gonorrhea. The child's hymen is intact. There is no evidence of bruising or penetration. The child's mother states that her daughter has been "acting funny" since she stayed overnight with an uncle two weeks earlier. The child is shy, clings to her mother, and denies sexual contact with anyone. The mother does not believe that her brother had any sexual contact with the child.

The physician is faced with a difficult decision. While the child obviously needs further medical attention, her symptoms and the etiology of her infection are so vague that he is uncertain whether an investigation for abuse is warranted. He favors his suspicions and reports the case to the police, but they are unable to obtain any new information. The uncle's test for gonorrhea is negative. Based on the lack of evidence, the case is dropped. The family agrees to medical follow-up for the child but declines other social or public health nursing services. The physician is angry with the police because they were unable to find evidence to substantiate the suspicion of abuse. The police are frustrated with the health care personnel because medical findings were inconclusive. If the child was abused, she remains at-risk of further abuse. In such cases, our current health care and legal systems do not provide adequate protection for the child.

The examples given above suggest the possible extremes in medical-legal investigation of cases of suspected sexual offenses against children. The latter example represents the majority of cases in that the nature of the offense, the lack of evidence, parental reluctance, and the child's immaturity often make it impossible to determine what actually occurred, much less to identify the offender and construct a case against him. However, even in cases where the findings permit the identification and apprehension of a suspect, the child may be subjected to further stress and confusion as the case is brought to trial.

In many jurisdictions, cases involving sexual abuse or assault of a child will be handled by the criminal courts, the civil or family courts, or both. Child protection and therapeutic intervention are the primary objectives of the family courts. However, proceedings under criminal law are designed to effect the trial and punishment of offenders. The criminal courts make no provision for the psychological or cognitive functioning of children, either in their status as victims or their role as witnesses.

Child victims of sex offenses, who have already had to provide detailed and repeated accounts of the incident to medical personnel and the police, may be required to attend a line-up to identify the assailant. They may be required to give evidence at preliminary and pretrial hearings and before a grand jury. If and when a criminal case comes to trial, they must testify in the presence of the alleged offender, in front of a jury, and often, in an open courtroom.

During the trial, children are expected to behave like miniature adults. Throughout the many proceedings, they are expected to remain consistent. As has been discussed, the statements of young children may change over time as fact and fantasy become interwoven. Further distortions may be introduced by the court process itself, as the child perceives the importance attached to the assault by lawyers, judges, and other officials. Nevertheless, discrepancies in a child's testimony often are viewed as deceit, instead of confusion or misunderstanding.

Many parents are reluctant to subject their child to such a lengthy and stressful process. If the sexual act was nonforcible and the offender was a parent, relative, or some other person close to the family, the decision to prosecute becomes even more difficult. In some cases, the conviction of an offender who is a family member or an important figure to the family (such as a paramour of the mother) may mean the loss of economic or emotional support. In addition, a parent may fear the publicity and social stigma that could arise from the case or the possibility of retaliation by the offender. It is not surprising, then, that many families do not wish to press charges.

In 1969, the American Humane Association published a study of 250 cases in which a child (age 15 or younger) was the victim of a sex crime committed by an adult. One of the objectives of this study was to evaluate the impact of court proceedings on the victim and family. Of the 250 cases, over 80 percent were reported to the police and the remainder to other agencies. Subsequently, 17 percent of the parents withdrew the complaint; 12 percent considered withdrawal; and 14 percent of the cases were dropped because the offender was "unknown." Arrests were made in 173 cases, and 61 percent of the alleged offenders were immediately released on bail or personal recognizance. There was an average of six court appearances per case. Nearly half of the cases that went to court were dismissed.[1]

No definitive information is currently available concerning the specific effects of the legal process on sexually abused children. Some researchers maintain that the emotional damage resulting from participation in the trial far exceeds the harm caused by the abusive incident itself.[2] Others hold that children, who were well-adjusted prior to the assault and who are given adequate support, can endure the temporary stress of the legal process without ill effects.[3] In spite of contradictions in research findings, it remains clear that children involved in the adult world of laws, courts, and criminals need special guidance and support.

Health, legal, and social service professionals working together can do much to alleviate the potential problems of children involved in legal proceedings. They can provide anticipatory guidance and emotional support to child victims and their families. They can work together to reduce the number of interviews and statements required of a child. They can work toward insuring a speedy trial by keeping delays and continuances to a minimum.

But what about the cases that never go to trial? These are the majority of cases. How can the police, health personnel, and social service workers protect a child when there is insufficient evidence of abuse, or the family is reluctant to cooperate with the prosecutor, or the child is too immature to testify, or the offender is never found?

When confronted with such cases, physicians are sometimes reluctant to contact the police or protective service investigators. Often, they are concerned that the family and, particularly, the child will only be forced to undergo further questioning with little likelihood of finding a satisfactory solution to the problem. They also may fear that they will alienate the family by involving the police or other outside agencies, thus losing contact with a child who may need follow-up medical care. It is important, however, that physicians and other health professionals take into consideration the need for legal as well as medical intervention in cases of suspected sex offenses involving children, not only to protect the individual child from possible re-assault but also to protect other children in the community. An aspect of the police role which is frequently overlooked is the deterrent influence generated through the fact of police involvement. This influence may be particularly important in cases in which there is a possibility of child neglect or those in which the parent seems to be protecting the suspected offender. If the police are brought into the case, even if there is insufficient evidence to prosecute, the parent may make more strenuous efforts to protect the child in order to avoid further police intervention.

Fortunately, many police officers, especially those in special sex offense units, are skilled at interviewing victims of sexual assault and their families. Those who are less experienced with such cases usually welcome opportunities to participate in special training sessions. Police officers and attorneys frequently need more information concerning the limitations of the physical examination and its bearing on evidence and the specialized interviewing techniques appropriate for use with children. In addition, the concerned police officer wants and needs to know the resources available to him when there is insufficient evidence to construct a case, but the child remains at-risk of abuse. In these cases, it may be possible for the physician or other health or social service professional to arrange to see the child more often, to spend more time talking with the parent, and, in general, to try to intervene on the child's behalf.

While each profession obviously offers special and necessary skills in handling these cases, there is a critical need for better communication and increased coordination among all service providers. When a police officer, health professional, and social service worker share information, discuss alternatives, and function as a multidisciplinary team, it becomes far more likely that a plan can be developed that will safeguard the child and the community.

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# SEXUAL ABUSE OF CHILDREN: SELECTED READINGS

## PART II

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# Introduction

Part II of this book is comprised of materials selected to represent a broad range of issues and perspectives associated with the diagnosis and treatment of child sexual abuse. Some of the following chapters were written specifically for inclusion in this book; others have been reprinted with permission from other sources. Several of the chapters focus on the problem of father-daughter incest and the issues associated with the long-term treatment that is often required in such cases. They have been included not only because Part I is focused primarily on a short-term, crisis intervention approach to family management, but also because incest continues to be among the most troubling and difficult forms of child abuse to identify and treat.

Several of the chapters reflect very different points of view concerning various theoretical and clinical aspects of child sexual abuse. This broad range of perspectives is representative not only of the variety of professional disciplines that become involved with cases of sexual abuse, but also of the tentative, newly developing state of our knowledge and experience in dealing with the problem.

It is hoped that the ideas and clinical experience contained in these chapters, as well as the personal accounts written by victims themselves, will encourage continued investigation and reporting of promising approaches to the prevention and treatment of child sexual abuse.

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# CHAPTER IX

# Humanistic Treatment of Father-Daughter Incest

Henry Giarretto, Ph.D.

The incest taboo is found in all known cultures, ancient, primitive, or civilized. It is generally agreed among social scientists that the essential purpose of the taboo is to optimize the survival and expansion of social systems.[1] Incest rules remain the most sternly enforced regulations for sexual relations and marriage throughout the world. But as social systems differ so do incest rules. To this day, laws defining and penalizing incestuous relationships vary markedly among nations and in the United States. In England, the law regards incest only as a misdemeanor. The penalties for incest in the U.S. range from a $500 fine and/or 12 months in Virginia, to a prison term of 1 to 50 years in California.[2] In most but not all states, first cousin marriage is illegal. Rhode Island permits first cousin marriage only between Jews.[3] For the purposes of this chapter, incest is defined as sexual activity between parent and child or between siblings of a nuclear family. The focus will be on father-daughter incest, as treated by the Child Sexual Abuse Treatment Program (CSATP).

Dread of incest is buried deeply in the unconscious of man and evokes emotions that are volatile and unpredictable, among them, repugnance, uneasy fascination, fear, guilt, and anger. This confused state finds expression in obscene comments or nervous disinterest when the subject is brought up in conversation, or quickly erupts into hostile behavior when an incestuous situation is discovered. Professional helpers themselves are not free of the incest dread. Many react either evasively when a case is referred or irresponsibly by failing to comply with child abuse reporting statutes. Nor can criminal justice personnel claim immunity from the panic induced by incest since their effect on sexually abusive families usually adds up to either rejection of the child's plea for help, if the evidence is not court-proof, or severe punishment of the entire family if the offender confesses. Finally, social scientists must also be afflicted with the dread of incest. How else can we account for the paucity of studies on incest which, with few exceptions, are superficial in conception and scope?

Typically, the repertory of law enforcement officials in the handling of father-daughter sexual abuse is ineffective and unpredictable. In one instance, the police officer or the district attorney may simply drop the case because of insufficient evidence even though there is strong suspicion that the victim's accusations are based on fact. The emphasis on a provable law violation has the effect of the community's turning its back on both the child and the family, thus leaving them in a worse condition than before. The child feels abandoned and must now face her hostile father, mother, and siblings alone. Often the father, though he may not repeat the crime, uses subtle retributive measures such as restrictions, extra chores, ostracism, etc.

In another instance, the criminal justice system, seeking sound, indisputable evidence, descends on the child and family with terrifying force. From the clinically detailed police reports, it appears that the only interest in the child is for the testimony she can give towards conviction of her father. The entire family is entangled in the web of retribution. The child is picked up and brought to a children's shelter, often without the mother's knowledge. The father is jailed, and the mother must place her family on welfare. In sum, the family is dismembered, rendered destitute, and must painfully try to find its own way to unification.

Neglect of the sexually exploited child by the American community is vividly dramatized by Vincent De Francis in a 1971 report presenting the results of a three-year study in New York. He stresses that, "the victim of incest is especially vulnerable. The child is overwhelmed by fear, guilt, and shame. Substantial damage to the point of psychosis may ensue." As a rallying cry for action he adds: "I firmly believe that no community, rural or urban, can say such cases are unknown to it. Suffice it to say the problem of sexual abuse is a real one! It is a problem of immense proportions! It is pervasive!"[4]

## Incidence and Effects of Incest

De Francis's alarm may not seem justified in view of the small number of detected incest offenders recorded annually

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by western nations. Over the period 1907-1938, Weinberg [5] determined that detected incest occurred in about one to two cases per million people in the United States; in Europe, the number of detected incest offenders ranged from one to nine cases per million. These rates seem to hold up to 1960.[6] All writers agree, however, that the low figures are the tip of the iceberg: that the laws discourage detection, and that data gathering methods render comparative studies extremely difficult if not impossible.

In the United States, some improvement in detection and treatment of child abuse is developing as a result of rising public agitation. One tangible outcome of this pressure was the passage in 1974 of the Child Abuse Prevention and Treatment Act, which led to the establishment of a National Center on Child Abuse and Neglect in the Children's Bureau. Douglas J. Besharov, Director of the Center, clearly spells out the position of the new federal resource on the overall problem of child abuse and neglect:

> The reality of child abuse is so awful that a harsh, condemnatory response is understandable. But such reactions must be tempered if any progress is to be made. If we permit feelings of rage towards abusers of children to blind us to the needs of the parents as well as of the children, these suffering and unfortunate families will be repelled and not helped. Only with the application of objective and enlightened policies can treatment, research, prevention and education be successfully performed.[7]

Other hopeful signs are the expansion and bolstering of child abuse reporting laws by many states, the increased attention being given by the media and the growing number of hotlines, several offering 24-hour service exclusively to calls on child abuse. Though major interest has been on child battering and neglect, some attention is slowly turning to sexual molestation. In a recent issue of *Children Today,* devoted entirely to child abuse, Sgroi [8] submitted an article in which she deduces that the above-mentioned developments had much to do with a sharp increase in reported incidents of child sexual abuse in Connecticut. The number of such incidents reached 76 in fiscal year 1973, and rose markedly to 172 cases in fiscal year 1974, apparently as a result of strengthened child abuse reporting statutes, the opening of a hotline, and a persistent public education effort.

The CSATP serves Santa Clara County, which has a population of 1,159,500 (December 1973). In 1971, its first year of operation, 36 cases were referred. The annual referral rate increased slowly over the following two years, but during fiscal year 1974 the rate accelerated sharply to 180 cases. This burgeoning rate can only be attributed to added coverage by the media and to growing confidence in the CSATP approach. Even the rate of 180 cases of recorded incest in a population of 1.1 million inhabitants does not provide an accurate estimate of the actual prevalence of incest in Santa Clara County. Although this is a large increase from the two incest cases per million estimated for this country by the writers cited above, the true incidence of incest has yet to be established. All available figures are at best educated guesses.

More telling than guesses on the number of actual cases is the social price paid for the neglect of incest, which is beginning to surface through recent studies revealing the effects of incestuous experiences on child victims. James [9] interviewed 200 prostitutes in Seattle and found that 22 percent of the women had been incestuously assaulted as children. For several years, Baisden [10] has studied Rosaphrenia: "An individual who cannot accept her own sexuality regardless of how she practices sex." He discovered that an inordinately high percentage of women so afflicted were raped as children. (Here, rape is defined as sexual exploitation of girls by much older males.) Concentrating on a group of 160 women, whom he tested for Rosaphrenia, he found that 90 percent had been raped during childhood, 22.5 percent by fathers or stepfathers.[11] The Odyssey Institute in New York interviewed 118 female drug abusers to ascertain their sexual history. It was found that 44 percent of the women had experienced incest as children. The 52 incest victims confided that, of the 93 different incestuous offenders, a total of 60 were in the parental generation, and of this group 21 percent were fathers or stepfathers.[12] It is notable that in each of these three studies of troubled women, a background of father-daughter incest emerged in over 20 percent of the subjects.

### **Father-Daughter Incest**

Father-daughter incest is potentially the most damaging to the child and family. Certainly it is the form most frequently prosecuted by the courts. A typical father-daughter incestuous relationship imposes severe stresses on the structure of the family. The father, mother, and daughter roles become blurred and this engenders conflict and confusion among family members. The most bewildered is the daughter, who is at an age when her budding sexuality requires a clear and reassuring guidance. The familiar father has suddenly put on the strange mask of lover. She never knows which role he will play at any given time. Her mother, too, becomes unpredictable. At one moment, she is the usual caring parent; at another, she sends subtle, suspicious messages that can only come from a rival. The girl's relationships with her siblings are also adversely affected as they become aware that she has a special hold on their father.

Of course, each family has its own unique cast of personalities, and the dramatic twists and turns which they enact are of infinite variety. But the following composite case history is fairly typical of the families we have been treating and how the authorities reacted before CSATP.

### ***Leslie***

Leslie is ten years old when her father begins his sexual advances. She has always been close to her father. When he tentatively begins to fondle her, she finds the experiences strange but pleasurable. Slowly the sex play becomes more sophisticated as it progresses to mutual oral copulation and, at puberty, to intercourse. Their meetings, which at first were excitingly secretive, now become furtive and anxiety-ridden. Leslie is about to enter the difficult teenage years when the mounting tension within her becomes unbearable. Her father is now interfering unduly with her peer relations. She senses that his fatherly concern over boys who are paying her attention is tainted by jealousy. She no longer can tolerate body contact with him and tries to resist, but he refuses to stop. Ashamed to confess the affair to her mother, she turns desperately to an adult friend, who immediately calls the police.

Though the policeman tries to be kind, Leslie is frightened by the power and authority he represents. His probing questions are excruciatingly embarrassing. But an odd feeling of relief intermingled with exhilaration comes over her as she realizes that her secret has now been exposed and her father's power over her broken. Her anxiety returns when she is brought to a children's shelter. Despite friendly attempts by attendants to make her stay pleasant, Leslie feels alone and threatened. This is the first time she has been forcefully separated from the family. She is overwhelmed by mixed emotions of fear, guilt, and anger, and is convinced she will never be able to rejoin her family or face her friends and relatives. Since there is suspicion of inadequate protection by her mother, a foster home is found for her. But she will not adjust to the new family, as this confirms her fears that she has been banished from her own family. Though often told that she was the victim of the incestuous relationship, Leslie believes she is the one who is being punished. She enters a period of self-abusive behavior manifested variously through hostility, truancy, drug abuse, and promiscuity.

### *Jim*

Jim, Leslie's father, a successful accountant, is in his mid-thirties when he becomes aware of deep boredom and disenchantment with his life. He feels stalemated in his job, and his prospects for advancement are poor. There is growing estrangement between himself and his wife. She no longer seems proud of him; in fact, most of her remarks concerning his ability as a provider, father, or husband are critical and harassing. Their sexual encounters have no spark and serve only to relieve nervous tension. He fantasizes romantic liaisons with girls at work, but he has neither the skill nor courage to exploit his opportunities.

Jim finds himself giving increasing attention to Leslie. Of all his children, she has always been his favorite. She is always there for him, accompanies him on errands, snuggles close beside him as they spend hours together watching TV. (His wife has no interest in this pastime; at night, she is either taking classes or studying with her classmates.) As Leslie cuddles beside him, he becomes keenly aware of her warmth and softness. At times she wiggles on his lap sensuously, somehow knowing that this gives him pleasure. He begins to caress her and "relives the delicious excitement of forbidden sex play during childhood," as one client expressed it. But this phase is soon engulfed by guilt feelings as the relationship gets out of hand and he finds himself making love to her as if she was a grown woman. Between episodes he chokes with self-disgust and vows to stop. But as driven by unknown forces he continues to press his sexual attention on her. He now senses that she is trying to avoid him and, no longer receptive to his advances. Though he doesn't use physical force, he relies on his authority as parent to get her to comply. He becomes increasingly suspicious of her outside activities and the seemingly continual stream of boys who keep coming to the house. With a sinking feeling, he notices that she is beginning to respond to one of the boys. He cannot control the feeling of jealousy the boy evokes or his craven attempts to force his daughter to stop seeing him.

Jim's trance is suddenly shattered one evening as he returns home from work. A policeman emerges from the car parked in front of his home and advises him that he is under arrest. Numb with shame and fear, he is transported to the police station for questioning. Though informed of his constitutional rights, he finds himself making a fully detailed confession. Jim is eventually convicted on a felony charge and given a jail sentence of one to five years. His savings are wiped out by the lawyer's fee of several thousand dollars. He finds imprisonment extremely painful: from a respected position in society he has fallen to the lowest social stratum. His fellow inmates call him a "baby-raper." No one is more despicable. He is segregated and often subjected to indignities and violence. His self-loathing is more intense than that of his inmates. He gradually finds some relief in the fervent resolution that, given the chance, he will more than make it up to his child, wife, and family. A well-behaved inmate, he is released from jail in nine months. But he has lost his job and, after weeks of job-hunting, settles for a lower position. Jim faces an uncertain future with his wife and family.

### *Liz*

The explosive reaction of the criminal justice system leaves Jim's wife, Liz, in shock and terror. She is certain that her family has been destroyed. There are subtle hints that she may have condoned the incestuous affair in the questioning by police and even others she once regarded as friends. She has failed both as wife and mother. Her feelings toward her daughter alternate between jealousy and motherly concern. Her emotional state vis-a-vis Jim is also ambivalent. At first Liz is blinded with disgust and hate at the cruel blow he had dealt her and vows to divorce him. Her friends and relatives insist this is her only recourse. But the rest of the children begin to miss him immediately, and she realizes that, on the whole, he has been a good father. Liz is also sharply reminded that he has been a dependable provider as she faces the shameful task of applying for welfare. Nagging questions, however, continue to plague her. If she takes him back, what assurance does she have that he will not repeat the sexual offenses with their other daughters? Will her relatives and friends assume that she has deserted her daughter if she allows him to return home? Will the authorities ever permit her daughter and husband to live in the same home again? Is there any hope for their marriage?

It is evident that typical community intervention in incest cases, rather than being constructive, has the effect of a knockout blow to a family already weakened by serious internal stresses. The average family treated by the Child Sexual Abuse Treatment Program is not at all like the incestuous family described in the literature. Weinberg, for example, reported that 67 percent of the families he studied were in the low socioeconomic bracket and that 64 percent of the incestuous fathers tested were below normal intelligence. He also noted that there was a disproportionate number of blacks in his sample.[13]

The 300 families who have been referred to the Child Sexual Abuse Treatment Program constitute a fair cross-section of Santa Clara County. The families are representative of the racial composition of the county, which is 76.8 percent white, 17.5 percent Mexican-American, 3.0 percent Oriental, 1.7 percent black, 1.0 percent other. The makeup of the work force leans towards the professional, semi-professional, and skilled blue collar. Average income is $13,413 per household. The median educational level is 12.5 years.

## The Child Sexual Abuse Treatment Program (CSATP)

In 1971, cases similar to the representative one described above aroused the concern of Eunice Peterson, a supervisor of the Juvenile Probation Department. She conferred with Dr. Robert Spitzer, consulting psychiatrist to that department. Dr. Spitzer felt that family therapy would be a good first step towards constructive case management of sexually abusive families. I was invited to undertake a pilot effort limited to ten hours of counseling per week for a ten-week period. Initial criteria were:

1. The clients would be counseled on-site at the Juvenile Probation Department.
2. The therapeutic approach would follow a "growth" model predicated on Humanistic Psychology.
3. Conjoint Family Therapy as developed by Virginia Satir[14] would be emphasized.

It was soon apparent that the new approach held high promise of meeting a critical problem of the community. The initial effort expanded slowly due to meager funds. But the pressure of client needs was so strong that perpetuation of the new community resource was assured. As the program got underway, I quickly discovered that conjoint family therapy alone was inadequate and, moreover, could not be usefully applied during early stages of the family's crisis. The fundamental aim of family therapy—to facilitate a harmonious familial system—was not discarded. Incestuous families are badly fragmented as a result of the original dysfunctional family dynamics, which are further exacerbated upon disclosure to civil authorities. The child, mother, and father must be treated separately before family therapy becomes productive. Consequently, the treatment procedure was applied in this order: (1) individual counseling, particularly for the child, mother, and father; (2) mother-daughter counseling; (3) marital counseling, which becomes a key treatment if the family wishes to be reunited; (4) father-daughter counseling; (5) family counseling; and (6) group counseling. The treatments are not listed in order of importance, nor followed invariably in each case, but all are required for family reconstitution.

Another important finding during early phases of the program was that traditional counselor-client therapy, though important, was not sufficient. The reconstructive approach would be enhanced if the family was assisted in locating community resources for pressing needs such as housing, financial, legal, jobs, and so on. This required close collaboration between the counselor and the juvenile probation officer assigned to the case. In 1972, another development adding to program productivity was the formation of the self-help group now known as Parents United. The insight that led to this step came when a mother of one of the first families treated was asked to make a telephone call to a mother caught in the early throes of the crisis. The ensuing conversation went on for over three hours and had a markedly calming effect on the new client. A week later, three of the more advanced mother clients met together for the first time, and after a few meetings, to which several other women were invited, Parents United was formally designated and launched. The members meet weekly, and, after a brief conference to discuss progress in growth and effectivity, the members form various groups: a couples' group; an intense couples' group size-limited to five pairs; a men's group; a women's group; and a mixed group. A separate organization, self-named Daughters United and composed of teenaged girls, meets earlier in the evening.

### Objectives of the CSATP

1. Provide immediate counseling and practical assistance to sexually abused children and their families, in particular to victims of father-daughter incest.
2. Hasten the process of reconstitution of the family and of the marriage, if possible, since children prosper best in normally functioning families headed by natural parents.
3. Marshall and coordinate all official services responsible for the sexually abused child and family, as well as private resources to ensure comprehensive case management.
4. Employ a treatment model that fosters self-managed growth of individuals capable of positive contributions to society, rather than a medical model based on the vagaries of mental disease.
5. Facilitate expansion and autonomy of the self-help groups initiated by the program and known as Parents United and Daughters United; provide guidance to the membership, such as training in co-counseling, self-management, and intrafamily communication; and in locating community resources—i.e., medical, legal, financial, educational.
6. Inform the public at large and professional agencies about the existence and supportive approach of the program, especially to encourage sexually abusive families to seek the services of the program voluntarily.
7. Develop informational and training material to enable emulation or adaptation of the CSATP model by other communities.

### Treatment Model

The therapeutic approach of the CSATP is based on the theory and methods of humanistic psychology, in particular the relatively new incorporation by the field of the discipline known as psychosynthesis, founded by Roberto Assagioli.[15] Other writers of importance to the CSATP are Carl Rogers, Abraham H. Maslow, Virginia Satir, Frederick Perls, Haridas Chaudhuri, and Eric Berne.

Assagioli agrees that many similarities exist between psychosynthesis and existentialist/humanistic views. Principal similarities are: (1) the method of starting from within, experiencing self-identity; (2) the concept of personal growth; (3) the importance of the meaning a person makes of his life; (4) the key notion of responsibility and ability to decide among alternatives; (5) the emphasis on present and future rather than regrets or yearnings for the past; and (6) the recognition of the uniqueness of each individual. In addition, Assagioli stresses: (1) the will as an essential function of self; (2) the experience of self-awareness independent of immediate I-consciousness of the various parts of ourselves; (3) a positive, optimistic view of the human condition; and (4) systematic use of didactic and experiential techniques that follow an individuated plan for psychosynthesis, the harmonious blending of mind, body, and spirit around the unifying essence—the self.[16]

Central notions in the treatment model are: the building of social responsibility; the realization that each of us is an important element of society; the belief that we must actively participate in the development of social attitudes and laws or be helplessly controlled by them. Chaudhuri gives firm emphasis to this imperative: "Since psyche and society are essentially inseparable, one has to take into account the demands of society. . . . One may criticize society or try to remold it. But one cannot ignore society or discard it." [17]

### Major Premises

1. The family is viewed as an organic system; family members assume behavior patterns to maintain system balance (family homeostasis).
2. A distorted family homeostasis is evidenced by psychological/physiological symptoms in family members.
3. Incestuous behavior is one of the many symptoms possible in troubled families.
4. The marital relationship is a key factor in family organic balance and development.
5. Incestuous behavior is not likely to occur when parents enjoy mutually beneficial relations.
6. A high self-concept in each of the mates is a prerequisite for a healthy marital relationship.
7. High self-concepts in the parents help to engender high self-concepts in the children.
8. Individuals with higher self-concepts are not apt to engage others in hostile-aggressive behavior. In particular, they do not undermine the self-concepts of their mates or children through incestuous behavior.
9. Individuals with low self-concepts are usually angry, disillusioned, and feel they have little to lose. They are thus primed for behavior that is destructive to others and to themselves.
10. When such individuals are punished in the depersonalized manner of institutions, the low self-concept/high destructive energy syndrome is reinforced. Even when punishment serves to frustrate one type of hostile conduct, the destructive energy is diverted to another outlet or turned inward.

Productive case management of the molested child and her family calls for procedures that alleviate the emotional stresses of the experience and of punitive action by the community; enhance the processes of self-awareness and self-management; promote family unity and growth, and a sense of responsibility to society. The purpose is not to extinguish or modify dysfunctional behavior by external devices. Rather, we try to help each client develop the habit of self-awareness (the foundation for self-esteem) and the ability to direct one's own behavior and life style.

### Method

It is necessary to generate a warm, optimistic atmosphere before productive therapeutic transactions can ensue with families that have broken the incest taboo. They must be given hope and reassured that their situation is not as singular or as disabling as they have been led to believe. Feelings of despair, shame, and guilt must be listened to with compassion, as natural expressions of inner states. Awareness and acceptance of current feelings, without evaluation, allows the clients to assimilate them and to move on with their lives.

I know that I must continually work at developing this attitude within myself. When I met my first family, it was easy to maintain an attitude of acceptance with the child and her mother. But in preparing myself for the session with the father, I read the lurid details of his sexual activities with his daughter, which included mutual oral copulation and sodomy at the age of ten. The compassionate, therapeutic attitude which I can now write about so freely (perhaps pompously) completely dissipated.

I was forced to go into deep exploration of my unconscious for its own incestuous impulses and found that my early religious upbringing had done its repressive work thoroughly. After confronting the revulsion and anger that I was projecting on my client, I was able to assume a reasonable therapeutic mien. When I actually met with my client, my problem was much less difficult than I had anticipated. The raw feelings of despair and confusion had needed to be attended to, and my own hangups had become less intrusive. I cannot overemphasize the importance of self-work on the part of the therapist. This is the central theme of workshops I conduct for individuals who want to help incestuous families.

### Self-Assessment and Confrontation

Once a working relationship has been established and the highly charged emotional climate subsides, the clients begin to take an inventory of personal and family characteristics. Initially, during this exploration, I underscore the positive traits. What does the girl, for example, like about herself? What does she appreciate in other family members and the family as a whole? Before she can be motivated to work actively for personal and family growth, she must be convinced that she and the family are worth the effort. From this positive stance, the clients can then proceed to identify weaknesses and maladaptive habits that need to be improved or eliminated. These might include uncontrolled use of drugs, food, alcohol and cigarettes; hostile-aggressive behavior that interferes with progress in family, school, and work-relations; sexual promiscuity; inconsistent study and work habits; and, typically, the inability to communicate effectively, especially with important persons in their lives.

As clients gain confidence in their search for self-knowledge, they begin to probe the painful areas connected with the incest. In what may be termed a confrontation-assimilation process, I encourage the child, father, and mother, as well as other family members, to face and express the feelings associated with the incestuous experience. It is indicated that buried feelings (fear, guilt, shame, anger), if not confronted, will return as ghosts to harass them. The feelings cannot be denied; they will have their effect somehow. If confronted now, they will lose their power to hurt them in the future. With some clients, the pain-provoking memories can be dealt with fairly early in the therapy; with others, I find it prudent to proceed more slowly.

Although I listen with compassion and understanding to the father's feelings, I will in no way condone the incestuous conduct or go along with pleas for mercy, such as that he is cursed and forced into incest by evil forces, or that he suffers from an exotic mental disease. He eventually is induced to admit the bald fact that he was totally responsible for the incestuous advances to his daughter. No matter the extenuating circumstances, including possible provocative behavior by his daughter, his actions betrayed his child and wife and their reliance on him as father and husband. Personal responsibility for the incestuous behavior is often objectively acknowledged by the men during group therapy and in sessions with their wives and daughters.

As a general rule, the mother will admit eventually that she was party to the incestuous situation and must have contributed to the underlying causes. Certainly, something must have been awry in her relationships with her husband and daughter. In order to relieve the daughter of feelings of self-blame and guilt for endangering the family, she is firmly told by her mother and, as soon as possible, by her father, that she was the victim of poor parenting. This step is also important for regaining her trust in her father and mother as parents. In time, however, she will confide that she was not entirely a helpless victim and is gently encouraged to explore this self-revelation.

Up to this point, the therapeutic approach is similar to that used by many humanist psychologists, particularly those of the Gestalt school.[18] The major objective of these first steps is to bring to awareness certain conscious and unconscious components of the individual personalities, as well as those that comprise the "personality" of the family. An important feature of the treatment is deliberate coaching in the techniques of self-awareness so that each individual can develop independently the skill of observing his own growth process and that of the family.

### Self-Identification

The last two phases of the treatment program draw on the writings of Dr. Assagioli and others in psychosynthesis. A key notion during the later phases is that the self is a unique entity which is more than the changing functions of mind, body, and spirit. A strong sense of self-identity must be internalized by an individual before he can experience self-esteem. Developing this line of thought, the counselor points out that the self in each family member should be a relatively stable center, which is more than the roles each plays as daughter, student, mother, wife, father, husband, or worker; more than the transient feelings of hostility, guilt, shame, etc.; more than the changing body states of pain and disease. Further, it is indicated that the marriage and the family also have integrating centers that are also more than the daily drama enacted by the principals.

### Self-Management

Once the idea of the self is entrenched and distinguished from the changing elements of personality, the concept of self-management is introduced. The assumption is that everyone can learn to control the way he behaves and ultimately the course his life will take. Each person in the family can behave purposefully to realize his potential and move deliberately toward self-actualization. The marriage and the family, conceptualized as separate organisms, can also be given purposeful direction. A major milestone is reached when the client acknowledges that all his past and current experiences are available to him for personal growth. He will assimilate all experiences, disown none.

A particular psychological school or discipline is not rigidly adhered to in attempting to satisfy the aims of the therapeutic model. Though the model roughly falls under the umbrella of humanistic psychology, other theories and methods, such as the psychoanalytic or the behavioral, are not denigrated or dismissed a priori. To avoid a mechanical, step-by-step approach, the last three phases of the therapeutic program are not developed in strict sequence. After initial efforts to bring about a good working relationship, I use an iterative strategy in guiding the client through the concepts and processes of self-assessment, self-identification, and self-management. They are developed more in parallel than in serial fashion.

A variety of techniques are employed in implementing the therapeutic model. None is used for its own sake; instead, I try to tune into the client and the situation and try to apply a fitting technique. In most instances, experiential techniques are called upon that elicit affective responses; however, cognitive and spiritual needs are not neglected. When indicated, I will briefly discuss the strategy and progress of the therapy and answer questions from the client. Certain clients who begin to internalize and practice the techniques at home report profound spiritual experiences. These clients are given special exercises that help them to expand and integrate the spiritual awakening.

Principal sources of the techniques come from psychosynthesis, Gestalt therapy, conjoint therapy, psychodrama, Transactional Analysis, and personal journal keeping. To maintain continuity, exercises that can be done at home or at work between meetings are given to the client. Many of these techniques were described in detail in an earlier publication.[19]

### Preliminary Results and Milestones

1. No recidivism reported in the more than 250 families receiving a minimum of ten hours of treatment and formally terminated.
2. Compared to preprogram outcomes the integrated, compassionate approach indicates that:
    (a) The children are returned to their families sooner; 90 percent within the first month, 95 percent eventually.
    (b) The self-abusive behavior of the children, usually amplified after exposure of the incestuous situation, has been reduced both in intensity and duration.
    (c) More marriages have been saved (about 90 percent), many confiding that their relationships are even better than they were before the crisis.
    (d) The offender's rehabilitation is accelerated since the counseling program is started soon after his arrest and continues during and after incarceration. Previous to CSATP, individual and marriage counseling, if any, occurred after release from jail.
    (e) In father-daughter incest, the difficult problem of reestablishing a normal relationship is more often resolved and in less time.
3. Parents United has grown from three mother members to about 60 members, of which half are father-offenders. Daughters United, comprised of teenaged victims of incest, has also grown substantially. Both groups are becoming increasingly self-sufficient; several of the older members act as group co-leaders.
4. In addition to self-help benefits, the Parents United formula is proving to members that they can become a

strong voice in the community, a significant realization to those members who used to regard themselves as the pawns of civil authorities.

5. Offenders, who formerly would have received long jail or prison sentences, are now given suspended sentences or shorter terms due to increasing recognition of the CSATP by the judiciary as an effective alternative to incarceration.
6. The difficult goal of mobilizing typically disjointed and often competitive services into cooperative efforts is gradually being reached.
7. Due to the public education work the referral rate has increased to about 180 families annually; about 60 percent of the referrals come from agencies other than the police or Juvenile Probation Departments, or directly from people heretofore fearful of reporting the problem.
8. The CSATP is receiving nationwide coverage by the media. Staff members and, more importantly, members of Parents United have appeared on several TV and radio programs, and the CSATP has been the subject of numerous newspaper and magazine articles.
9. Hundreds of informational packets have been sent to requestors throughout the country to abet the aim of having the CSATP serve as a model for other communities.
10. Several presentations and training seminars are conducted each year for professional groups by the writer and staff members. The presentations now include mothers, daughters, and fathers of the families treated for incest who are willing to answer questions from the audience—a significant breakthrough.
11. The CSATP is involving many volunteers and graduate students, who make valuable contributions while being trained.
12. The CSATP is unique also in that it constitutes the only substantive attempt extant to apply the principles and methods of humanistic psychology to a serious psychosocial problem. Currently the program is obtaining financial support direct from the California legislature.

## Discussion

Current attitudes and laws regarding incest are myth-ridden and ineffective. Society is not attending responsibly to a problem vital to its own survival. The impact of civic authorities on incestuous families, particularly those in which the father is the offender, commonly adds up to either rejection of the victim's plea for help or disruptive punishment of the entire family.

I do not suggest that criminal laws in support of the incest taboo should be abolished and offenders should be dealt with exclusively by mental health workers. Reliance on the weekly therapeutic hour alone has not proved successful in the histories of several CSATP families. Typically, the mother had become aware that her husband was sexually exploiting their daughter and threatened to breakup the marriage if he did not obtain psychiatric treatment. The offender complied but stopped going to the therapist after a few sessions. A month or two later he resumed the sexual abuse of his daughter. In two instances, the fathers continued their offenses even while undergoing treatment. The motivating drive and/or therapy alone were not sufficient, and the troubled family was left with its problem. In five other cases in which punishment alone was employed, the deterrent effect hoped for proved equally inadequate. After serving long sentences, the five men came to the attention of the CSATP for repeating the offense with other daughters or stepdaughters.

The CSATP works closely with the criminal justice systems of Santa Clara County and other local counties. The promising results would not have occurred without the cooperation of the police, probation officers, and the courts. The police and probation departments are major referral sources. A distraught victim, mother, or friend will usually turn to the police for immediate help since they are available 24 hours a day. It is now a common practice for officers who investigate the cases to refer offenders and their families to the CSATP.

For the offender, the implication is that involvement in the CSATP is likely to be strongly considered by the judge and prosecuting attorney during court proceedings. His own lawyer will also urge him to join the CSATP. Though all offenders hope that their penalties will be softened by participation in the CSATP, many find it equally compelling to do so for the aid the program gives to their families. Usually each man soon realizes that the program will help him understand and control his deviant impulses and to reestablish sound relationships with his wife, the daughter he victimized, and the other children.

In all cases, the authority of the criminal justice system, and the court process, seems necessary in order to satisfy what may be termed an expiatory factor in the treatment of the offender and his family. It appears that the offender needs to know unequivocally that the community will not condone his incestuous behavior and that he must face the consequences. The victim and her mother also admit to deriving comfort from the knowledge of the community's clear stand on incest. All family members, however, will do their best to frustrate the system if they anticipate that the punishment will be so severe that the family will be destroyed—that they, in turn, will become "victims" of the criminal justice system, including the child-victim herself.

No matter what the reasons may be for admission of an incestuous family into the CSATP, it is our responsibility to help the family reconstitute itself as quickly as possible hopefully around the original nuclear pair. Even if the offender comes to the CSATP only for the purpose of saving himself, it is up to us to show him that he can reap more substantial benefits both for himself and his family from honest participation in the CSATP. Of course, the CSATP is not equally effective with all clients. About 10 percent of referrals will elude our efforts. They will not come in for the initial interview or will drop out soon after treatment has begun. Four couples were dismissed from the program because the father and/or his wife would not admit culpability and placed the blame entirely on the child-victim and her seductive behavior. In these instances, extraordinary effort was required in the treatment of the deserted child. After many attempts, three of the girls successfully adjusted to foster homes. They are now married and apparently doing well.

The CSATP is a growing community resource. Some of its objectives have only partially been achieved; others will be added, or dropped, or modified. But there is at least the beginning of a response to Vincent De Francis's clarion call to the American community to protect the sexually molested child.[20] Moreover, the CSATP complies with Besharov's request for enlightened intervention that considers the requirements of the entire family, the parents as well as the children.[21]

By working integrally with the criminal justice system, the CSATP shows promise of developing into a model for other American communities. Each community must be given the opportunity to treat incestuous families in a manner that is neither permissive or cruelly punitive. A national position should be taken on the incest taboo and laws enacted that are effective and consistent; the community must publicize these statutes and the penalties for violating them.

To prevent incest, the public must be educated to become aware of predisposing conditions and to take appropriate action. Finally, comprehensive procedures similar to the CSATP must be established in each community to treat sexually abused children and their families in order to enhance their chances for reconstitution and to prevent future violations.

## Addendum

As of March, 1979, the CSATP has provided services to more than 2000 families (approximately 10,000 individuals). As a direct result of the California Demonstration and Training Project, which was started in May, 1977, 18 new programs modelled after the CSATP, each with Parents United and Daughters & Sons United chapters, have been established throughout the state. Also, several child molestation programs in various states in the country have been markedly influenced by the CSATP approach. In early 1978, the California Department of Health funded an independent evaluation of the CSATP by Jerome A. Kroth. Dr. Kroth and his associates, applying statistical techniques, corroborated in substance the preliminary findings reported in this article.

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# CHAPTER X

# Advocating for Sexually Abused Children in the Criminal Justice System

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In recent years there has been much publicity about the ordeal of prosecution for the rape victim. Many states have initiated programs to address victims' rights, but it is too early to tell how victim advocate programs and related legislation will affect the rate of prosecution of rape and other sexual assault offenses.

It is not widely known that a significant number of sexual assault victims are children. National statistics on the incidence of sexual abuse of children are not kept. Many local jurisdictions do not have systems for gathering such information either. Incidents of child sexual abuse currently being brought to the attention of police agencies are probably only the most unusual or severely abusive cases. The number of child sexual assault victims referred to Seattle's Sexual Assault Center (SAC) at Harborview Medical Center for medical or counseling services has been increasing steadily since 1973. During the past year, over 40 percent of cases referred to SAC were victims age 14 or under. Nineteen percent of our total caseload was composed of children age nine or younger. Forty-one percent were sexually assaulted by members of their immediate families. The majority of child victims we serve are molested by an offender who is known to the child (85 percent). Although child molesters usually are not violent in the ways that forcible rapists are, child victims are usually confused and frightened as a result of the abuse, and sometimes physically injured as well. It has been our experience that child molesting is often a compulsive behavior; therefore, if the offender is not prosecuted for his crime, a series of children will undoubtedly be exposed to his abuse.

If child molesters are prosecuted, child victims must undergo the same processes as those imposed on adult victims, without benefit of special procedures or protection. This fact contrasts with the differential treatment which our society provides to minors in other areas of the criminal justice system. The United States was the first society in the world to establish separate criminal justice system procedures for juvenile offenders, based on the belief that children have experiences, capabilities, and vulnerabilities that are significantly different from adults. However, our society has not subscribed to protecting *all* children involved in criminal proceedings—only juvenile *offenders*. If a child is a *witness* to a crime committed by an adult, that child is drawn into the adult criminal justice system, where there is usually little allowance made for his or her more limited abilities. Two negative effects can result: (1) child victims and their families report being further traumatized by investigation and court procedures; and (2) prosecutions of child molesters are unsuccessful because the crimes are either not reported initially or the child witness is not able to convey the information necessary to corroborate the sexual offense charge in court.

If our society believes that sexual molestation of children is a serious crime, then it seems that special techniques must be adopted within the criminal justice system which not only encourage the cooperation of child witnesses, but, at the same time, acknowledge the inherent limitations on a child's performance.

Although procedures for filing charges of sexual abuse and trial preparation are somewhat different in each jurisdiction, there are some common basic requirements. We shall assume that most systems require several separate interviews in which the child witness is asked to review details of the assault; these are usually conducted by the police department and prosecuting attorney's office. (In Seattle, there is a minimum of three basic interviews.) The child is expected to give repeated and vividly detailed accounts of the incident, as well as events preceding and following it. The child is also expected to provide a series of strange adults with a description of the suspect and additional, accurate information on dates, times, sequences, and locations. Usually, it is not possible for a parent or advocate to be with the child during these interrogations. The child may be required to identify the offender by picture or line-up, and there may be a preliminary hearing, during which the child again must recount details of the sexual abuse. If the suspect does not plead guilty, a trial may ensue in which the child must testify again and also be subject to cross-examination in an open courtroom while facing the accused. The above process takes place over many months. (The average time for adjudication of these cases in Seattle is six months.)

It is no wonder that many parents and mental health

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professionals fear that the effect of criminal proceedings on the child will be more emotionally traumatic than the assault itself. At the Sexual Assault Center, we have observed on numerous occasions the negative effects of a child's involvement in investigation and prosecution proceedings. It is our opinion that the stress inflicted on child sexual assault victims in the criminal justice system results from (1) an inadequate understanding of children and their capabilities by system personnel, and (2) misconceptions held by these personnel about the nature of the crime of child molestation. Without basic knowledge in both areas, criminal justice system personnel are ill-equipped to elicit necessary information from the victim or maintain her cooperation and that of her family.* Since the victim is usually the only witness, she is the prosecution's most valuable resource, particularly because there is rarely any corroborating evidence. Increased reporting of sexual abuse of children and improved conviction rates depend on changing those aspects of the legal system which inhibit victim cooperation. This article will present some general information about child development as it relates to child molestation. We will also suggest some different strategies for accommodating the child witness in criminal justice system proceedings.

It is generally accepted that normal child development progresses in sequential, overlapping phases of increasingly complex learning. The child masters skills at one level and moves on to the next stage. Physical, intellectual, and social growth occurs in this fashion. Although there are many different theories of child development, the major theoretical frameworks all recognize similar phases, beginning with infancy and continuing through early childhood, preschool-age, school-age, and adolescence. Some of the major skills which the child must acquire relate to social interactions, language, conceptual thinking, and the ability to deal with an increasingly more complex societal framework. It must be remembered that each child learns at a different rate, and generalizations are never strictly applicable to any one child.

Knowledge of the basic principles of child development has immediate significance for law enforcement personnel who investigate sexual abuse cases. Obviously, a child cannot be a witness unless she has acquired verbal skills. In cases involving pre-verbal children, other witnesses or corroborating evidence are necessary in pursuing prosecution. Between the ages of two and four, children establish verbal language as the primary mode of communication. Although preschool children (ages four through six) usually can talk well, they cannot understand concepts well, and, therefore, their verbal skills may imply a better comprehension than actually exists. Preschool children do not understand metaphors, analogies, or irony; they can memorize, but without comprehension. The narrative account of a four-year-old child tends to be rambling and disjointed, containing both relevant and irrelevant details. Children in the preschool-age group engage in intuitive thought; they can accept connections between events but do not understand causality. The preschool child entertains one thought at a time and cannot conceive of multiple thoughts as an integrated whole. Although a child can vividly recall isolated events, often triggered by association with a familiar sight or sound, the memory is usually spotty and lacking in continuity and organization. For the four-to-six-year-old, concepts of time, space, and distance are usually personalized and not logical or orderly.

Emotionally, preschoolers tend to be outgoing and spontaneous, with few internalized limits. They can be stubborn, quarrelsome, and scatological. Children in this age range usually spend most of their time in play, particularly dramatic, acting out play. Although fantasy becomes an important element in the repertoire of preschoolers, they can usually distinguish fact from fantasy. When lying occurs, it is usually the child's attempt to make something look better or to escape a problem situation. Children in this age group are unable to practice real deception because they still invest adults with complete authority and believe that adults would perceive any lie. In addition, these children still depend totally on their families to meet all physical and emotional needs. They have an egocentric perception of the world with only tentative awareness of any relationships which do not involve them directly. It is apparent that the abilities of the preschool-age child fall far short of the traditional requirements which the legal system has for witness performance.

School-age children (ages six through eleven) are better prepared to respond to the expectations of an interviewer. These children are beginning the gradual shift from total reliance on family to a peer culture. They are aware of themselves in different roles—as students, children, peers. But they still depend on parents for refuge and support. Girls and boys tend to group together in same-sex bands with separate interests. A group loyalty develops as the child seeks recognition from the group, with its rituals, traditions, and rules. It is at this point, as children begin to establish a sense of separateness, that they begin to practice deception and guile around adults. Although they may become sullen, insolent, and taciturn with adults, they seldom lie about major issues. This is particularly true in matters concerning justice and equality. They are very sensitive to any apparent unfairness or differential application of justice. They are often rigid and harsh on each other and become legalistic nit-pickers with adults. Intellectually, school-age children have increasing mastery of language and symbols, can locate themselves in time and space, and gradually move from absolutism to relativism. Thinking still remains concrete rather than abstract, but they are voracious learners who are rapidly developing all skills and are intensely interested in understanding how things work.

The specific emotional consequences of sexual abuse cannot presently be predicted, but the intensity of distress reported by child victims generally correlates with the reactions of the parents and authorities who become involved (doctor, counselor, policemen, attorneys, etc.). When the assault is nonviolent and occurs only once, it is clearly less traumatizing than the extremely violent or longer-term situation. If the child is not believed or is accused of provoking the incident(s), she will acquire additional negative feelings about herself. Too often, parents who *do* believe their child's account can still be ignorant about the dynamics of child molesting; they may increase problems for their child by over-reacting and treating her as if she were different or changed. The child often interprets this as blame. Even when the parent responds in a calm, appropriately supportive, believing manner, the ac-

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***Since 88 percent of child victims served by the SAC have been girls, we will use the female pronoun for the sake of clarity.**

tivities of the criminal justice system will usually exacerbate the child's distress. Perpetual discussion of the sexual assault in repeated interviews over many months discourages rapid resolution of assault-related trauma for both child and parents. The criminal justice system must address the conflict that exists between a child victim's emotional needs following a sexual assault and the requirements for prosecution of the case.

The first major issue in pursuing a sexual assault case is establishing the credibility of the child witness. Adults are extremely reluctant to believe a child over an adult, as all children well know. Popular mythology dictates that children often fabricate tales of sexual assault despite a lack of any research to substantiate this belief. Thus, it is incumbent on the investigator, police, or prosecutor, to dismiss such misconceptions and evaluate each case on its individual merits. Unfortunately, this task usually is made difficult by the absence of corroborating evidence. Often, the investigator must rely entirely on evaluation of the child's testimony. The inherent reluctance of a child to challenge adult authority and the possibility of retaliation which the child may be risking should be kept in mind when beginning an investigation. There are criteria which can be used to assess a child's statement. The words the child uses, the acts she describes, and the degree to which she is able to recount the event to a stranger can all be measured against characteristics of that child's developmental stage. If the overall adjustment of the child to family, school, and peers is satisfactory, it is highly unlikely that she would be deviant in one area of her personality development (i.e., producing an elaborate fabrication of sexual abuse).

There are many useful strategies for improving the investigation of those crimes by applying knowledge of children's behavior to the investigative process. Many of the following suggestions may seem obvious, but, unfortunately, these procedures have not been adopted in many jurisdictions. When an initial complaint of sexual abuse or assault is received, the usual procedure is for the victim to be interviewed by a series of law enforcement personnel, including a uniformed officer, detective, and prosecutor, as well as by a doctor, and perhaps a counselor or children's protective services worker. A child has a limited capacity to respond to repeated questioning. Therefore, in order to most effectively elicit information and maintain the victim's cooperation, these various agencies might develop a coordinated approach. Joint interviewing could be established, or, preferably, one person could be designated to take the victim's statement. This should be done as soon as possible following the assault, because the passage of time significantly affects a child's ability to testify. The initial interview could be videotaped to afford the prosecuting attorney an opportunity to review her capability as a witness. One comprehensive statement should be adequate to file charges.

The setting of the interview and the manner in which it is conducted have considerable bearing on the child's performance as a witness. A crowded, noisy, bare-walled precinct room or a formal attorney's office with a massive desk are not conducive to eliciting an easy flow of information from a child. She should be interviewed in a quiet, private room which allows her some room for exploration. A child cannot comfortably sit still on a hard-backed chair for any length of time. Toys, books, crayons, and drawing paper should be available to aid in occupying and relaxing the child so she can converse more easily. Younger children will need a parent or familiar person present to feel secure enough to talk during the interview, whereas older children may be too embarrassed to talk freely if a parent is present. (Children generally develop a strong sense of modesty around the age of six or seven.)

The interviewer can help alleviate anxiety by establishing a personal rapport with the child. The interviewer should be relaxed and casual, and preferably not in uniform. Communication can be established by inquiring about the child's interests, family and friends, pets, school and neighborhood, and by allowing her, in turn, to ask questions of the interviewer. A simple explanation of the function of the interviewer and the agency (police, prosecutor, etc.) will help the child understand and, therefore, cooperate with the proceedings.

The language and the number and kind of questions used are the crucial aspects of the interview. Although it seems obvious that the level of language employed by the interviewer should apply to the child's level of comprehension, this rarely occurs. Attorneys are by far the worst offenders in this area. Children in the legal system are regularly subjected to legal jargon and terminology that even their parents do not comprehend. Much of the concern about credibility stems from the confusion which results when the child does not understand the question and, therefore, answers incorrectly or incompletely. Because the attention span of children is shorter than that of adults, the interviewer should carefully choose questions that elicit the most information. It is a waste of time to ask questions which the victim cannot answer. For example, a four-year-old, who does not yet perceive time in a logical, sequential order, need not be asked about dates and times of the abuse. Too often, the interviewer is limited by his own fixed approach to investigation and does not adapt to the child's situation. The child may become frustrated and directly or indirectly refuse to discuss the incident further. In such cases, criminal justice system personnel, parents, or mental health professionals often decide the child is not a credible witness or that she cannot "handle" the prosecution procedures.

Time is an important element of the entire process. There is often a long delay between each subsequent step which can seriously limit a child's ability to testify. Whenever possible, the proceedings should be accelerated. A child's memory quickly blurs; although a child victim may clearly recall the molesting incident, other details may become indistinct. In Seattle, it is usual for four to six months to elapse between reporting of the crime and a trial date. Even adults have difficulty remembering accurately after this much elapsed time. In addition, children are often expected to sit for lengthy interviews on different occasions or to wait for several hours before testifying. This can also damage the testimony because of the child's limited ability to wait.

Court appearances (preliminary hearing, grand jury hearing, or trial) are the most difficult encounters for child witnesses. The courtroom may be unfamiliar and intimidating to even the most secure adults. Astonishing as it may seem, children are generally required to testify while sitting alone on the witness stand; often, they must speak into a microphone while facing the alleged assailant in an open courtroom which may be filled with spectators. Questioning may go on for hours with the child expected to sit quietly and respond without benefit of explanation or clarification. The prosecutor who initially interviewed the child may not handle the case for trial, and usually additional interviews are conducted prior to trial. Even prosecutors who have managed to establish a rapport with the child find it impossible to transfer it to the trial setting because, once in the courtroom, they seem compelled to revert to legal terminology. When cross-examination occurs, it is usually unsympathetic, despite the victim's youth, since the defense attorney's usual tactic is to attack the credibility of the victim. Prosecutors are often reluctant to object for fear of appearing too protective of the witness; judges hesitate to interject for fear of swaying the jury. Thus, the child is abandoned to a set of abstract beliefs in justice, and we can ask if justice is indeed being carried out without the complete participation of the witness.

One possible model to address this problem is assigning a legal representative to advocate for each child appearing as the victim/witness in a criminal matter. This person would be appropriately qualified with knowledge of child development and the law and could speak out in court when the questioning became inappropriate to the child's age, level of comprehension, or emotional state. The child victim advocate role would not interfere with the proceedings or abrogate the rights of the defendant.

Including the child's family throughout the process can provide a valuable aid to the child and to the criminal justice system in pursuing prosecution. It has been our experience that parents of child victims are usually not informed of steps in the prosecution; yet, at the same time, they are expected to cooperate fully with the investigation. Parents are asked to wait patiently while their child is interviewed. They pay for medical exams to obtain medicolegal evidence, arrange to take their child out of school, rearrange their own schedules for various interviews, and pay for parking, mileage, and babysitting costs. Throughout this lengthy, inconvenient process, parents often are not given opportunity to express their concerns regarding their child's involvement in the various procedures. The parent who strongly wishes to pursue prosecution of the offender and is assertive about seeking information is labeled "too eager," and the reluctant parent is accused of obstructing justice. When parents are informed and educated realistically about the various proceedings, they can be invaluable in building a case. Their cooperation can be enlisted by treating them respectfully and involving them in decisions, consulting with them about their child, answering their inquiries, and patiently allaying their fears. We feel that the opinion of the family should be obtained even when the child victim cannot be involved (such as in making sentencing recommendations). Many parents find their experience with the criminal justice system so unpleasant that they vow never to report another crime. Families should be encouraged to participate not only when their own child is involved but as responsible citizens who believe the system can work.

In spite of the fact that the community at large is outraged by the crime of child molesting, the legal system has failed to develop mechanisms which support and encourage successful prosecution when the victim/witness is a child. If criminal prosecution is the avenue society chooses to deal with this critical problem, then society has an obligation to adjust the requirements of the legal system to conform to the special needs and abilities of children. These changes would clearly necessitate specialized training for all official figures involved with the investigation and prosecution, as well as development of new and flexible procedures. Legislation should be explored to provide the legal foundation for special protection of the child witness.

# CHAPTER XI

# Sexual Abuse of Children: A Clinical Spectrum

Roland Summit, M.D., and JoAnn Kryso, M.S.W.

Household sex education, sexualized play, incest, child molestation, and ritual sexual exploitation are all aspects of an interest of adults in the sexuality of children. On one end of the spectrum, there is a presumably altruistic dedication to sharing with a child the benefit of adult awareness and experience toward the goal of eventual sexual fulfillment. On the other end, adults who teach and demonstrate sexuality to children for the goal of immediate gratification are condemned as criminals. Snuggling with children under the covers on a cold Sunday morning can be one of the great joys of family living. A woman may remember fondly the warmth and strength of her father's body against her, while another recalls with guilt and loathing the intrusion of unwanted paternal intimacies. The objective distinctions between loving support and lustful intrusion are disquietingly subtle.

Some people, uncomfortable with subtleties, attempt to deny and prohibit any hint of sensual outreach toward children. Others, oblivious to the subtleties, exhort parents to bring their children into the bathroom and bedroom to dispel the secrecy and guilt traditionally associated with sex. Most parents find themselves somewhere in the middle, a little discontent with traditional prohibitions but suspicious of radical change. When common sense and intuition break down, these parents seek guidance from magazines, ministers, and mental health professionals.

Professionals in mental health and human services should be able to cope with subtle value judgments and to distinguish between affectionate and abusive behavior. They must be aware of the complex interplay among family sexual roles and be cognizant of the relative importance of oedipal forces at particular stages of family development. They should be able to evaluate the risks of various sexualized behaviors according to a reliable body of diagnostic and prognostic knowledge.

Unfortunately, there is little professional agreement about models of optimal childhood sexual development or family interaction. There is even less accord concerning pathological variants. Conceptual models tend to be drawn from psychoanalytic theory, with a curious paradox; for all the pivotal importance of concepts of incest in the foundation of psychodynamic theory, and for all the continuing fascination with incestuous fantasies, there seems to be a deliberate reluctance to confront incest as a real event.* In the legacy of Freud's pioneering studies, therapists have tended to focus attention on the child's wish for the parent and the difficulties of resolving fantasized oedipal conflicts. Recollections of parental sexual intrusions, whatever their reality base, have tended to be interpreted as stereotypic fantasies.[17] For all the emphasis on the primal scene and the myth of Oedipus, there has been little research or training in the practical management of the family romance.

The psychiatric literature prior to about 1960 viewed incest as an exotic, virtually negligible phenomenon taking place between retarded, seductive girls and inadequate, sociopathic fathers. In 1962, Cormier,[3] portrayed a more human, everyday picture of incest and introduced the probability that the incidence of incest vastly exceeded reported figures. Reliable incidence figures and statistically relevant data on prognosis have yet to emerge.

Reported cases of child sexual molestation are only the visible fraction of a much larger problem. In a retrospective survey of 1200 college-age females, 28 percent reported a sexual experience with an adult prior to age thirteen. Only six percent of these incidents had been reported to authorities.[5] The American Humane Association estimates 200,000 to 300,000 cases of female child molestation in the United States per year, with at least 5000 cases of father-daughter incest.[1] In communities where active efforts are made to invite referral and treatment of sexual problems, the response has exceeded

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***Freud's own deliberations on the importance of incest offer an interesting historical footnote. After hearing anamnestic accounts of incest from several women with hysteria, Freud theorized that incest was the psychic trauma responsible for the neurosis. Further analysis indicated the incestuous experiences were fantasies derived from the needs of the patients, rather than trauma inflicted from the outside. Freud felt devastated at the repudiation of his theory, and considered abandoning the analytic approach altogether. The salvation of psychoanalysis came with Freud's epic decision that children construct their own traumatic fantasies as their instinctual needs conflict with outer events. In effect, whether the incest happened or not was immaterial.[4]**

these estimates. The Child Sexual Abuse Treatment Project in San Jose, California, has experienced an explosive increase of referrals and self-referrals, to a present annual incidence of 165 father-daughter incest cases per million,[8] which would project to some 36,000 cases nationally.

The experience of the authors in the Los Angeles area indicates a much higher prevalence and a much more significant mental health impact from sexual abuse than is commonly recognized. We are convinced that incest is a specific variant of child abuse with identifiable antecedents and predictable consequences. We are also impressed that incest itself is a symptom common to a diversity of parental conflicts, and that a classification of that diversity is required to achieve a differential specificity of management and prognosis. In this paper, we shall attempt to classify the spectrum of parent-child sexual behavior patterns as a practical guide to understanding and working with the human side of sexual abuse.

Input for this paper is drawn from a wide base of sources encountered during an eleven-year span of psychiatric community consultation. Our experience includes hundreds of consultations with protective service workers and law enforcement personnel concerning sexually abusive families as well as direct contact with dozens of patients referred for evaluation and treatment of sexual abuse. Individuals otherwise invisible to clinical attention have shared with us their concerns about sexual aspects of parenting in parent education classes, professional training courses, public audiences, and women's awareness groups. In addition, we have had extensive contacts within Parents Anonymous[14] with members who have been very frank in discussing a wide range of problems in parenting.

## Incest and Child Abuse

Almost every society in history has had a taboo against incest.[10] People tend to assume that the incest taboo is a natural outgrowth of human decency, and that sex with offspring is unnatural and inherently repugnant. However, the taboo may have evolved for quite the opposite reason: as a practical defense against a very natural experience. People who live together, who depend on each other for love and support, and who have intimate daily contact with each other will tend to develop sexual relationships with each other. Children respond gladly with their whole bodies to loving contact. They want to be treated by their parents as something special, and the sharing of sexual feelings could be very exciting. The parent bears the entire responsibility to define and maintain appropriate limits of intimacy. For many parents, a mythic taboo alone fails to guarantee that responsibility.

There are two general characteristics common to those who sexually abuse their children. It is these two problems, rather than the quality of sexual attraction, that separate the abusers from the more moderate parents. One problem is a lack of impulse control. This may be as a result of transient stress or it may be characteristic of the individual. The second problem is a confusion of roles. The child is regarded at times as something other than a child, or as a surrogate of someone else. The child becomes an object for the needs of the adult without adequate recognition of the inappropriateness or inadequacy of the child to meet these needs.

These two dynamics, the lack of impulse control and the confusion of roles, are common not only to sexual abuse but also to child abuse in general. All parents get angry with their children. All parents have sensuous feelings toward their children. The abusing parent acts on those feelings in a less controlled way and expects of the child an adult level of performance and a quality of devotion and gratification that no child can fulfill.

Just as there is a shifting and invisible line between constructive discipline and dehumanizing punishment, there is a vague borderline between loving sensuality and abusive sexuality. Just as both discipline and sensuality are vital to the growth of children, the backlash of these qualities by abusing parents can blight a child for life.

The remainder of this discussion will examine that borderline as it merges into frank sexual abuse, defining in the process some guidelines to prognosis and management of the various levels of parent-child sexualization. We will examine a progression of categories of sexual involvement. The categories represent an ascendency of apparent individual and social harmfulness. At one end of the spectrum are behaviors that most would identify as variations of normal behavior. At the other extreme are the more bizarre and apparently malicious aspects that most would agree are clearly criminal and demanding of aggressive intervention.

## The Spectrum of Parent-Child Sexuality

### *1. Incidental Sexual Contact*

This first category involves parents' attempts to cope indirectly with erotic interest or dependency needs toward their children. The response is controlled and self-limiting, often without much understanding of the erotic or dependent basis for the behavior. Sometimes control is excessive, as a parent tries to deny or undo an unacceptable feeling.

For example, several mothers have told us of their erotic or orgasmic response to breast feeding. One woman welcomed an unexpected bonus of motherhood. Another woman could not reconcile any erotic response with her concept of the mother role; she never nursed a child again and tried not to think about the experience, let alone confide in anyone for help.

Curiosity provokes various kinds of sexual exploration. Mothers may touch the penis of an infant to test its response and may be intrigued by the phenomenon of infantile erection. Some women report feeling very guilty about this, even years after an isolated experience. A father may feel curious to see or feel the "private parts" of his daughter. A male single parent may feel guilty even bathing his daughters.

Sexual tension may be diverted into games involving teasing, mock spankings, and wrestling. One mother reported an after-bath game of "gotcha" in which she would grab for the penis of her six-year-old while he gleefully jumped to avoid her.

A less genital but more potentially harmful behavior is the tendency of some single mothers to sleep with a child, usually the oldest son. Both mother and son seek comfort in the loss of the father and neither seems able to sleep comfortably without the other. The boy may sleep with his mother to age ten or twelve. The mother denies any erotic potential in the absence of genital contact or arousal. She overlooks how stimulating the body contact is to the child and how it prolongs sensual dependency on the mother. The boy tends to remain excessively attached to his mother and to have difficulties later on with adult sexual object choice. This situation presents an excellent opportunity for preventive casework; most such mothers respond well to informed questioning and brief counseling.

As children approach adolescence they provoke a more characteristically adult sexual response. Adolescent girls describe two kinds of overreaction by their fathers. One is withdrawal behavior, in which the father is so threatened by his potential attraction that he stops holding or touching his daughter and becomes visibly threatened by any contact with her. The other reaction is overtly seductive or self-gratifying. There may be lingual kissing, exploration of breasts, and other frankly erotic intrusions, all in the guise of "fatherly love." In a family where communication is open, a girl will often register her distress to her father or to her mother. Perceptive parents will appreciate the impact of this misguided affection and bring it under control. Exploratory behavior becomes a more serious problem if family trust and communication are already impaired, as we will examine in a later classification.

Another incidental response to adolescence is household voyeurism. Men may station themselves around corners with mirrors or outside of slightly open doors to watch their daughters undress. They are content that this has no impact on their daughters because they are sure their daughters are not aware of it. The girls report otherwise, usually with a strong sense of disillusionment and distress.

These behaviors have an emotional significance in the development of the child, but they fall outside of the usual definition of sexual abuse. They are enumerated here for two reasons: to illustrate a spectrum of behavior and to alert professionals to areas to explore as people seek help with vague complaints about changes in parental relationships. One must listen carefully to adolescents who come in and vaguely say, "I'm not getting along well with my folks any more; dad isn't the same as he used to be."

### *2. Ideological Sexual Contact*

Certain parents may encourage specifically sexual activity in the belief that increased sexual expression is beneficial for the child. Potential arousal, anxiety, or guilt are sublimated through idealization and rationalization by parents who are sometimes strikingly naive about the consequences for the child:

*A mother in a parent-education class expressed concern when she encountered her five-year-old son attempting intercourse with his female playmate. A few questions from the instructor illustrated that the boy and his friend were stimulated by their habitual perusal of* "Penthouse" *magazine, which the parents felt should not be hidden away. The boy's sexual interests were further piqued by the mother's pleasure in sharing afternoon showers with him. The mother's obvious pregnancy also aggravated potential oedipal conflicts, as indicated by the child's question, "Mommy, when daddy did it to you before I was born, did he do it in bed or was it here in the shower?"*

In their search for an appropriate expression of modern sexual values, these parents had unknowingly stimulated more sexual curiosity than they were prepared to accept.

The ideological category presents a dilemma of values when it involves explicit sexual behavior without clear criminality or intent to harm.

*A sex counselor expressed a philosophy that sexual inhibition was bad, and that post-Victorian prudery was our greatest social problem. His solution to the problem was to set up a laboratory of sex education at home. He invited his young son and daughter to watch him and his wife in various sexual activities, and then gave them permission to play with each other in the privacy of their own room. The man expressed pride that his family was so free of sexual hang-ups.*

Idealization is institutionalized by radical groups such as the Rene Guyon Society. Based on the writings of Guyon [9] and a grotesque distortion of the early work of Freud, the society claims that children need sex with compassionate adults to reduce violent antagonisms supposedly aroused by societal repression and guilt. Sexual repression is advanced as the cause of depression, suicide, delinquency, gang warfare, assault, and a host of other social problems. Under the slogan "Sex by year eight or else it's too late," the group advocates sexual rights for children, including abolition of laws restricting incest and sexual abuse. The Guyon Society claims a membership of "2000 parents and psychiatrists." [20]

### *3. Psychotic Intrusion*

In this situation, the adult has a psychotic level of confusion in reality testing and object choice, or personal sexual impulses may be projected to some kind of outside influence. The children become the object of a psychotic system. This is probably the least frequent of the several types of sexual contact; most people involved in sexual abuse are not psychotic.

### *4. Rustic Environment*

The next level is one of the stereotypes that dominates popular concepts of incest. There is a prevailing folklore that isolated mountain settings promote incest and inbreeding. We suspect that rustic incest jokes supply a prejudicial scapegoat for urbanites not entirely immune from incestuous conflicts, and that regional variations in incest behavior are minor. Nevertheless, we do encounter an occasional migrant family that seems to accept as natural the practice of intrasibling and intergenerational incest. The helping professional faces a vexing problem in adapting that kind of value system into the dominant cultural mores, and in deciding what level of active intervention is indicated.

### *5. True Endogamous Incest*

Endogamous (within marriage) incest develops as a surprisingly subtle distortion of normal family relationships. Although impulse control is diminished, the offenders are individuals who are not notably impulsive and who may appear quite well-adjusted and well-functioning within other areas of their lives. The breakdown occurs only when extraordinarily strong attractions develop as an outgrowth of role disturbances within the family, often limited to a specific point in time. The specific dynamics of endogamous incest are outlined clearly in the classic paper by Cormier [1] and examined within a broader context in a recent review by

Henderson.[10] Giarretto confirmed the pattern within a clinical sample of over 300 cases.[6, 7]

The father is the key to the disturbed dynamics and is responsible for the choice to eroticize the relationship with the daughter. Whatever else is said in sympathy with his motivations, and regardless of the contributions of the wife and daughter, that responsibility must be emphasized and must be identified in any therapeutic encounter. The role distortion in the father involves a flight from stressful, disappointing adult realities into roles characteristic of a more exciting, more fulfilling period of his life. Some of the mechanisms are seen in the so-called male menopause, when a man may withdraw from his family and seek a reendorsement of youth and masculine vitality via love affairs with younger women. A difference here is that the incestuous offender is more inhibited, more conventional, and more rigidly devoted to his role as a family man; he is determined to fulfill his sexual needs within his marriage. If his fantasies of fulfillment have not come true with his wife, he is increasingly frustrated and potentially angry.

The wife of the incestuous father is typically disenchanted with her husband and her marital role. She is no longer invested either in endorsing her husband's ego needs or in trying to wring pleasure from a tired relationship. She may be somewhat depressed by the loss of her youth and the weakening of her girlish attraction. She may be resentful of the adolescent attractiveness of her daughter, and may look for ways to demean her and to hold back her social development. The wife may turn outside the family for endorsement and diversion, absorbing herself in a job, church, or social commitments. For the first time in her married life, she is free to be away from home; she can count on her daughter to take her place.

The third corner of the incestuous triangle is, of course, the daughter. She is entering adolescence and is learning to transmit the magical vibrations our society requires of the emergent woman. She radiates the fragile innocence of a child mixed with the vaguely destructive allure of the temptress. A girl needs support to keep up emotionally with her sudden rush to womanhood. Her most trusted allies in this process should be her mother and father. She looks to her mother as a model of feminine behavior and then tests the new model on her father. A father should be harmless to flirt with. He should be approving, admiring, and responsive to her growing sexual attraction, and he should provide a controlled, self-limited prototype of the sensual experiences she will develop with other men as an adult. Both father and mother should have a shared sense of the appropriateness of this prototype romance, and both should be comfortable in recognizing and defining the appropriate limits. Incestuous activity begins when the father needs to bend those limits and the mother chooses to ignore them.

The man who bends the limits usually doesn't start out with the intention of seducing his daughter. By the time the relationship becomes sexualized, he relates to her more as if she were his wife: not the adult woman to whom he is married, but an imagined reincarnation of his bride-to-be. The daughter may have assumed many of the more ingratiating aspects of the wife's role: she greets him fondly after a miserable day at work, puts his food on the table, and entertains him at dinner. After she tucks the younger children into bed, she may pour him a drink and nestle beside him watching television. Through inheritance and conditioning, she has become an uncanny likeness of the girl who once spurred him to greater accomplishments, who made him feel loved and strong, and who excited in him an unquestioned virility and potency.

Just as the man is flattered and stimulated by his daughter's attentions, the girl is at first gratified by his more open affection. It is not her place to refuse her father, and she lacks the experience or the information to recognize all the implications of his increasing arousal. Trusting acceptance and curiosity are role-appropriate for her as she waits for her father to define the limits of this new game. If she tries to stop him, she is likely to find he is now deaf to her protests. A combination of parental possessiveness and sexual arousal have overpowered the protective role he would ordinarily offer.

In the aftermath of the initial sexual experience, the father typically feels guilty and frightened. He will tend to scapegoat the girl for leading him on and will almost always coerce her into silence with the threat of disgrace and family disruption. In his desperation, he may also threaten violence. The early ventures into incest may not have been premeditated but, once established, there tends to be a compulsion for repetition. The child feels used and betrayed by her father, and feels she has no worth except as a sexual object. She is alternately courted and demeaned, loved for her attraction and then hated for her power, often labeled as bitch, slut, or whore.

The second level of betrayal comes when the girl seeks escape. She may turn to her mother, only to be accused of lying or condemned for seducing the father. Even if the mother accepts the story, she may still fail to act. One daughter recalled the reaction: "They'll send your father to jail and we'll all end up on welfare. Is that what *you* want to do to us?"

The third level of betrayal comes from the helping institutions. The girl is punished by the demand for explicit, incriminating testimony and by being regarded as depraved and ruined through her participation. The father may deny everything, forcing the girl into an adversary role. Not uncommonly, the family will coerce the girl to recant her testimony to avoid court intervention, exposure, and disgrace. Even in the event of prosecution, the father may be acquitted, while the girl is assigned to a foster home. In any event the family is broken; the girl feels isolated and morally condemned. In her own mind, she comes to feel guilty and responsible.

A bizarre spinoff of the labeling process is the fascination the girl presents to others. She may be regarded by relatives as dangerously attractive. (It is no accident that most of our words for feminine appeal, like glamorous, fascinating, spellbinding, enchanting, bewitching, enticing, and charming are derived from witchcraft. Others suggest enslavement or physical threat, as in alluring, enticing, captivating, enthralling, ravishing, devastating, and stunning.) Publicly deflowered as she is, she is regarded as no longer deserving of respect or protection. We know of at least four cases where male relatives have attempted seduction after a girl has admitted incest with her father.

The results of incest conflicts are predictable and frightening. Deprived of self-worth and self-esteem, forsaken by parents, betrayed by other adults, cursed with a destructive concept of their own sexuality, many of these girls spend their lives searching for a redeeming relationship, yet retreating from positions of trust or intimacy. They expect rejection, betrayal, and punishment.

Even if the secret is contained, the girl's character development is affected by incest. The father abdicates his authority along with his parental responsibility. There is a struggle for power in which the girl exploits her position to demand favors and avoid parental limits. With this inversion of roles there is no hope of normal discipline and guidance. The father tries to be superauthoritarian in one area: limiting his daughter's access to potential boyfriends and outside social contact. The atmosphere is counterproductive of genuine growth and maturity for the girl. Sometimes the only escape is the transfer of the father's attention to a younger daughter. Several children may be involved serially, each one in turn ignoring the welfare of the younger sister.

### *6. Misogynous Incest*

This is a variation of endogamous dynamics in which fear and hatred of women are relatively predominant. (Remember that romantic idealization, disenchantment, and anger toward the wife are typical also of the prior category.) The offender has a history of conflict with his own mother, and a tendency toward violence and punishment of women. Wife-beating, rape, and physical abuse of children may be seen. The daughter is seen as a possession, and possessing her sexually is an assertion of his invulnerability to the control of women as well as an act of punitive defiance toward his wife.

Men of this type may conceptualize women in elaborate extremes, sanctifying the purity of the virgin and condemning the seductions of the whore.

*One man physically abused his daughter as an infant, then idealized and overprotected her until she was raped on the street at age eight. His rage and grief were compounded by his feeling, "They have taken my little virgin from me." He persuaded his wife that the girl should watch them make love to undo the violence of the rape. The wife was herself a victim of incest and family rejection, which seemed to paralyze any outreach for help. She waited for more evidence to confirm her valid suspicion that her husband had initiated the girl into an ongoing sexual relationship after the bedroom episode. After two years, and then only after the man punished his wife by openly demonstrating fellatio with his daughter on two occasions, she was able to call the police.*

Just as abused children are at risk of becoming abusing parents, sexually abused girls are at risk of selecting an abusive partner and failing to protect their children from intrusion. The man described above was typically hyperaggressive, hard-driving, and coercive of females. He had experienced success as a military police officer until he was psychiatrically discharged after physically battering the infant daughter he later seduced.

### *7. Imperious Incest*

This category represents a fusion of elements from the ideological, rustic, and misogynous categories. These men set themselves up as emperors in their household domain. They play out an incredible caricature of the male chauvinist role, requiring wife and daughters to perform acts of sexual fealty. One man, who initiated three daughters into his service, even constructed a throne for himself. The domestic grandiosity seems to compensate for an otherwise mediocre achievement level; such men tend to be displaced from rustic backgrounds, with poor education and few job skills. They may be highly religious, expressing rigid, fundamentalist Christian doctrines and quoting Scriptures to justify their domestic role.

*One such man entered into a sexual relationship with his nine-year-old daughter while functioning as a fundamentalist minister. The mother, an extremely passive woman who made no decisions for herself, refused to intervene, despite repeated entreaties from the girl and an older sister. The older sister finally sought help from a rape hotline thirteen years later, when she discovered her own seven-year-old daughter and the sister's three-year-old had been molested by the grandfather. The woman blamed her father for her own promiscuity, the sister's willingness to be beaten by her husband, a brother's "schizophrenia" and another brother's homosexuality. A third brother, at fifteen, had tried to seduce the caller's seven-year-old daughter. "We're all screwed up." After two generations of repeated sexual abuse and imperious domination, only one family member was able to seek outside help, and then only via an anonymous hotline. Hotline counseling enabled the caller to report the sexual abuse and to seek psychiatric evaluation for her daughter.*

### *8. Pedophilic Incest*

Some people have an erotic fascination with children. Males especially have the proclivity to retreat from castration fears and discomfort with peer relationships in search of a sex object they consider more innocent and less threatening.[16] Some act on their fantasies and take the risk of seeking out children in public places. Others resist any action (and in fact may repress even the fantasies) until they are overwhelmed with the stimulus and availability of their own children. A pedophile approaching a small child rarely attempts coitus; body contact, fondling, and oral contacts are more typical. Gender roles are somewhat less binding; a man may be attracted to boys as well as girls, even if his adult object preference is consistently heterosexual.

One slightly redeeming feature for the child is the relative freedom from stigma and guilt. Mother, relatives, and society at large are quick to protect the very young child and to identify the pathology in the father. Unfortunately, the very young child is unlikely to share daddy's secret game with others, and so may remain isolated from potential help.

### *9. Child Rape*

Most pedophiles are gentle creatures. They cherish tenderness and innocence, and will back off from fear and resistance in their intended partner. The child rapist, confusing masculinity with power, can feel sexually adequate only by frightening and overpowering his victims. His need to punish, his attraction to violence, and his poor impulse control, all coupled with perverse guilt and fear of discovery, put the child in extreme physical danger. This sort of chronically antisocial, potentially violent man is often found as a surrogate father living with a woman who is passive and self-punishing. He is not the sort of man a mature, well-adjusted woman selects as the father of her children.

It is important to recognize that recurring rapacious intrusions on children within a family are a function of the passive mother as well as the aggressive male.

*One mother of a seven-year-old girl left the room for some incidental shopping while her live-in boyfriend was ordering the little girl to strip and mimic her mother's coital posture. The man raped the child on that occasion, and for the next year-and-a-half imposed physically traumatic vaginal, anal, and oral intercourse. The girl pleaded for rescue but could not gain her mother's sympathy or protection. Neighbors reported hearing screaming and seeing discarded bedsheets stained with blood and feces. Both of the mother's two subsequent partners also molested the girl until she began to run away from home at age eleven.*

This case was investigated and taken to court on three occasions. In the first two instances the child was returned to the mother by judges sympathetic to the mother's assurances that she was participating in psychotherapy and determined not to resume her penchant for drugs and coercive mates.

### *10. Perverse Incest*

This last category is called "perverse" or "pornographic" in the absence of any better superlatives to describe kinky, unfettered lechery. These cases become more bizarre, more frankly erotic, more flagrantly manipulative and destructive than those in earlier categories. Many of them have a kind of self-conscious, sex-scene quality in which the individual seems to be trying to set up rituals to fulfill a variety of forbidden fantasies. Many of the people involved would qualify clinically as polymorphous perverse: without specificity or limit to their sexual needs. They are people who try to solve their conflicts through sexual activity, and their responsibility to their partner is of secondary importance to their own particular needs.

This group is called pornographic because of an apparent need to go beyond limits of socially acceptable sexual practice to explore whatever is most forbidden, with incest representing the ultimate taboo. Furthermore, the participants may want to record their achievements and to see themselves putting the fantasies into action; diaries, secret confessions, and Polaroid photographs seem to heighten their excitement. We are not suggesting that outside pornography creates the abuses, but rather that the abusers seem caught up in creating their own pornography.

Previous categories involved predominately one-to-one relationships, however disturbed or transient they might be. Multiple partners are more the rule here. There is an emphasis on flamboyance, freedom, and ritual pleasure.

There is a distressing similarity here to the characteristics of the "ideological" category outlined above. The crucial differences seem to lie in the motivations of the individuals and the capacity for restraint. Here, the activity with children is contrived to gratify perverse needs and the rationalization evolves as a denial of guilt. The child is exploited as an accessory of the adult; rather than preparing a child for eventual adult sexuality, the child is drafted and trained to enact lurid parodies of adult sexual function. The distinction depends on highly subjective and relative judgments. The following examples may help to illustrate the difference.

*A mother and father enlisted their children into shared sexual activity and then, having conditioned the children into orgiastic adventures, used them as bait to draw in neighborhood boys to provide the father with a continuing harem. Another case was uncovered when a vice-officer and his son infiltrated a social group advertised in the underground press. Men brought their preadolescent sons to scheduled meetings, trading the boys among themselves for extended orgies.*

A final case illustrates the restless progression of perversity characteristic of this group.

*A man enlisted his seven-year-old daughter as a sex partner. He soon introduced her into the ritual punishment and torture of her mother, including burning her face and genitals with a soldering iron. In time, he also involved the daughter's young playmate in a foursome. When the mother grew too guilty and depressed to participate, the father and the two twelve-year-old girls drove the mother to another city and forced her to leap to her death from a bridge.*

### Effects of Sexual Abuse

The categories of the spectrum appear to document increasingly abusive parental intrusions on children. Defining such intrusions as abusive requires evidence that they bring harm to the child. In our experience, the harm observed from incestuous encounters correlates not so much with the forcefulness or the perversity of the encounter as with the climate of environmental response. A child trapped in an encounter with a cherished parent may suffer greater psychological damage than another child rescued from an incestuous rape. Psychological harm seems to occur not so much in the sexual experience itself, nor even in the fact of exploitation by an adult. We believe harm results from the perception by the child that the sexuality is socially inappropriate and that the relationship is exploitative. This parallels the conclusion of Sloane and Karpinski [22] that incest is least harmful psychologically for the younger child, with the risks increasing as the subject approaches adolescence. The various aspects of guilt and betrayal are potentiated both by increasing sophistication in the subject and by guilt and ambivalence perceived in the parents. If the active sexual agent (father) and especially the nonparticipating adult (mother) are comfortable with the incestuous relationship, harm to the child is decreased.[18] Some authors contend that incest within an endorsing family can be nontraumatic [8] or even beneficial [19] to the child's emotional growth. Such findings may seem at first paradoxical and outrageous, but if valid they reinforce the original premise that incest can be a natural phenomenon and that taboos and conflicts are socially imposed.

We are convinced from clinical and consulting experience that incest can do substantial harm. Experience in Parents Anonymous underscores a striking prevalence of incestuous experiences in the childhoods of parents who now have problems with physical and emotional abuse of their children.[11] During the course of psychiatric consultation to Cedar House, a model therapeutic shelter for physically abusing families in Long Beach, California, it emerged that some 90 percent of the mothers seeking help for child abuse had been sexually abused as children.[15] Several of the young children of these mothers revealed through therapeutic play that they were currently involved in sexual relationships with the man in the house or with adult neighbors or friends. Giarretto [6] cited studies correlating incest with later prostitution and drug dependency, as well as a syndrome of feminine sexual incapacity. With the support of the women's liberation and consciousness-raising movement, many women are "coming out of the closet" to protest the incestuous traumas they have previously concealed. Specific questioning of chronically depressed, suicidal, self-deprecating women in psychiatric care reveals many patients who were sexually and physically abused as children but who have continued to shield their parents and themselves from the stigma of disclosure. We have studied cases of boys initiated sexually by their fathers who run away to the degrading, if lucrative, practice of prostitution and pornographic modeling.

There is a striking similarity in the reported reactions of incest participants: The children take over the responsibility and the blame from the initiating parent. The betrayal of parental responsibilities and the failure of responsible adults leads the child to feel he or she is fundamentally bad and unworthy of care or help. Sexuality, tainted with guilt and fear, becomes exaggerated as the only acknowledged aspect of attraction or power.[12] The child grows up expecting and deserving abuse, often searching endlessly and hopelessly for a redeeming experience with an older partner.

It must be recognized that these implications of harm are retrospective; they are based on complaints of people already identified as being harmed. To measure more objectively the effects of incestuous experiences there must be prospective research, as well as a more energetic search for incest participants who give no evidence of harm. Until reliable data are established, the potential for enlightened, constructive intervention will remain impeded by uncertainty and interprofessional misunderstanding.

The ambiguity of the clinical literature leads to ambiguity of social response. Although all states now have child abuse laws requiring reporting of sexual abuse, a federally sponsored Child Abuse Intervention Prescriptive Package states that there is neither sufficient evidence of harm nor sufficient optimism for treatment to justify legal intervention in intrafamily sexual abuse.[21] As clinicians involved in the daily tragedies of sexual abuse, we are appalled at such a nihilistic interpretation.

**Discussion**

The spectrum of family sexuality presents a number of implications for intervention and management. The increasing sexual pathology within the spectrum is paralleled both by increasing character pathology and increasing social alienation. Parents in each successive category can be expected to be less amenable to conventional psychotherapy and more resistant to intervention. At some point in the spectrum, voluntary outpatient treatment programs must be replaced by mandatory, specialized institutional programs. Given present limitations of knowledge and techniques, it must be recognized also that some individuals will be refractory to any known treatment, and that institutionalization may serve a purely protective function.

The endogamous incest family occupies the pivotal position in these considerations. Giarretto has demonstrated the value of a specialized multifocal outpatient program for such families.[6] [7] The Child Sexual Abuse Treatment Program in San Jose, California, works in collaboration with the probation department, providing a treatment alternative to prosecution and potential imprisonment. Justice system supervision provides what Giarretto calls "the hard edge of society" [6] in upholding the incest taboo and in protecting the rights of the child. Without the keen scrutiny of investigating agencies and the looming specter of public disapproval, there is a greater tendency to conceal material, to minimize the implications of the incestuous relationship, and to terminate therapy prematurely. In contrast to the widespread antipathy and pessimism usually leveled against incestuous families, Giarretto reports a successful rehabilitation in over 90 percent of families treated.[6]

In addition to specialized treatment programs for endogamous incest families, there should be encouragement of self-help programs for both adult and child participants. Alcoholics Anonymous, Parents Anonymous,[11] and Giarretto's Parents United and Daughters United groups [6] have demonstrated the unique effectiveness of a united peer group in building identity and self-esteem in the face of majority censure. Parents Anonymous invites involvement of people with sexual abuse problems; [23] some five hundred Parents Anonymous chapters are available throughout the United States.

The level of misogynous incest goes beyond the endogamous population reported by Giarretto. Success in outpatient programs and prognosis for family reconstitution are jeopardized in the misogynous group by the inherent character pathology and the poor basis for marital bonding. Yet one of our patients, described earlier in the misogynous category, achieved substantial improvement after arrest and treatment within a hospital milieu for sexual offenders. He insists he could not have changed without incarceration and an imposed milieu.

There is less reason for optimism with the imperious father or the child rapist. The devotion of the imperious father to his family can provide some leverage, but only if the family can support the need for outside control. By definition, the child rapist is criminally sociopathic, with only shallow transient relationships. We know of no effective treatment models for such men.

The women who accept misogynous, imperious, or rapacious partners deserve enlightened attention, not only for their own needs but for the protection of the children in their care. Many of these women were victims of sexual, physical, or emotional abuse as children; they have an incredibly undeveloped capacity for self-perception, self-esteem, and human initiative. It is our conviction that counseling or therapy alone does not meet the needs of such deprived, defensive individuals. We have seen striking growth in passively sex-abusing women within the Parents Anonymous self-help experience, coupled with firm limits and expectations from the justice system.

In all the abusive categories, the children deserve the first consideration. Every effort must be made to avoid further scapegoating and condemnation of the victim. Crisis outreach and protection are ideal, but support and reassurance can be helpful at any stage. We recently received a letter of gratitude from a thirty-year-old woman who had attended a sexual abuse training symposium, where she came to believe for the first time that she was not at fault and not permanently stigmatized by her childhood sexual experiences with a misogynous father.

Coordinated programs of prevention, intervention, and treatment will not develop without community concern and public support. Vast progress has been made in understanding and dealing with child abuse since Kempe and his colleagues first identified the battered child syndrome in 1962.[13] That progress depended on identification of the problem, publicizing the problem to professionals, initiating research, developing treatment resources and self-help programs, and generating a better-informed, more sympathetic, and less defensive public acceptance of the problem. That progress also required substantial investment of private, state, and federal monies and aggressive political action.

Sexual abuse is the most concealed, most distressing, and most controversial form of child abuse. We believe it deserves the same quality of enlightenment and helping resources that have revolutionized the approach to the other forms of abuse.

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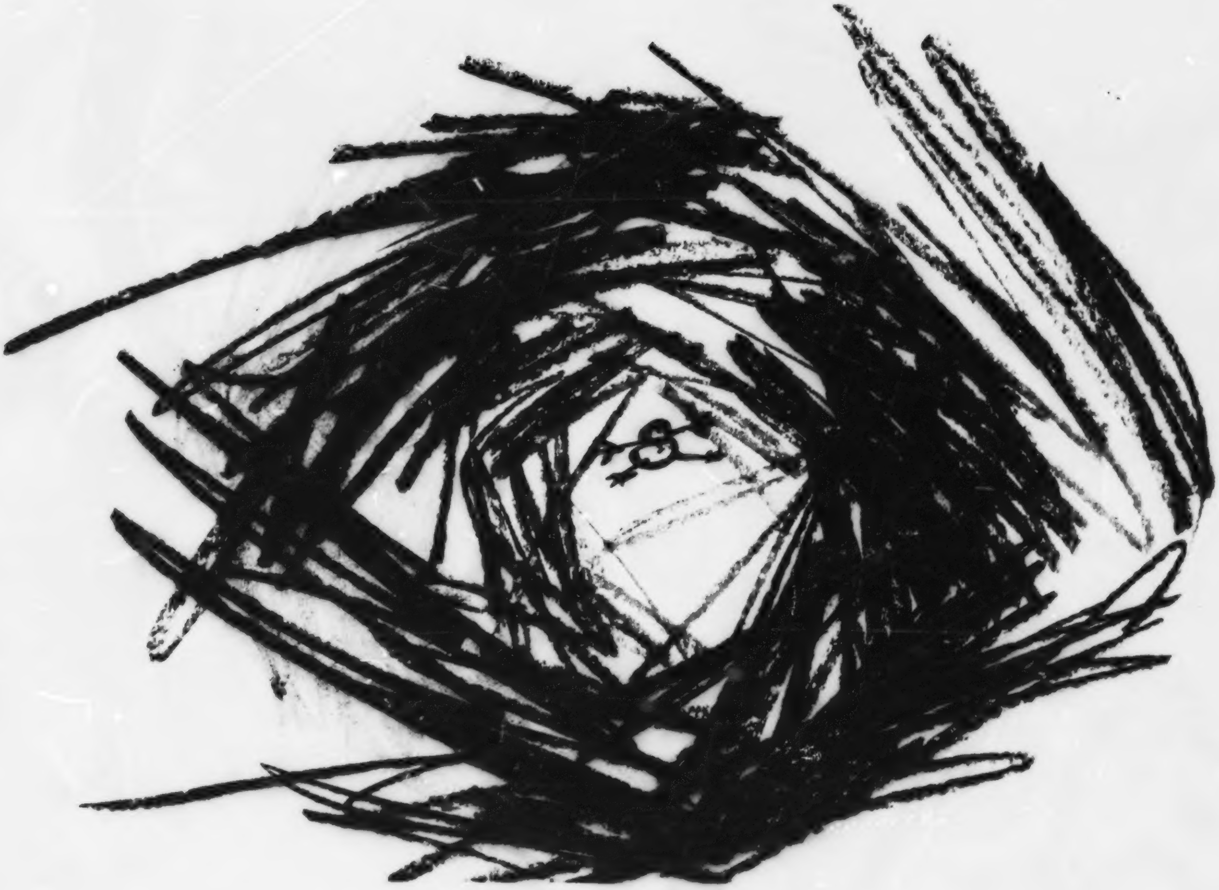


Fig. 1 *Age-innapropriate drawing by a seven-year-old girl whose doctor reported his suspicions of sexual abuse. A fifteen-year-old neighbor later confessed to vaginal penetration. The child's rage is expressed with angry lines surrounding tiny figure identified as "me." Figures, such as this one, depict poor body-image, and consistantly appear in drawings of abused children.*

A

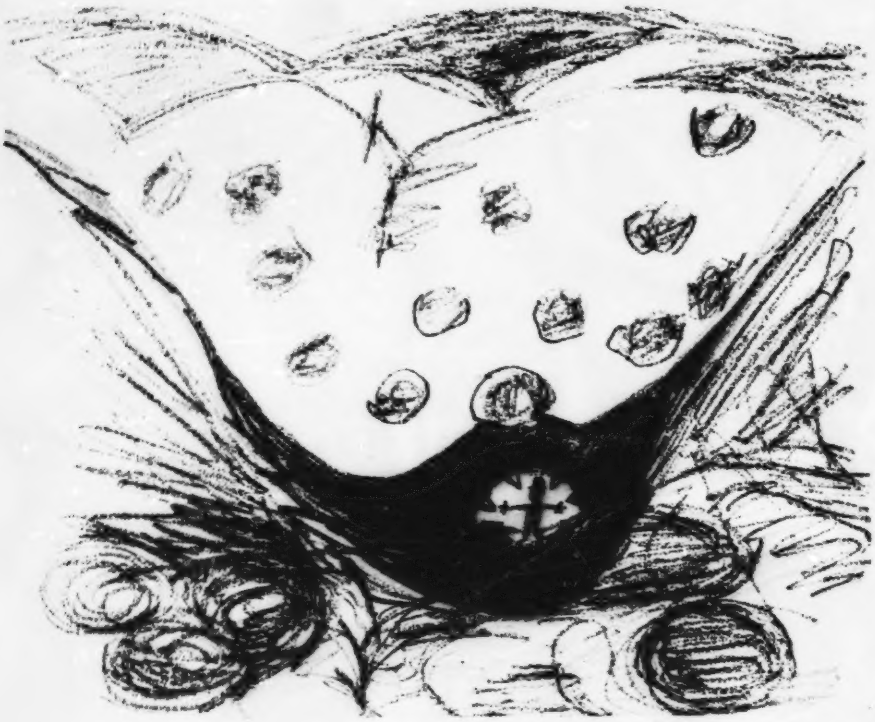


Fig. 2 *First free drawing by a nine-year-old male incest victim whose mother had been molesting him until he was placed in a foster home. The composition and figure-ground placement of forms indicate a downward, depressed,motion. The child depicted himself as trapped inside a circular, vaginal-like area surrounded by teeth.*

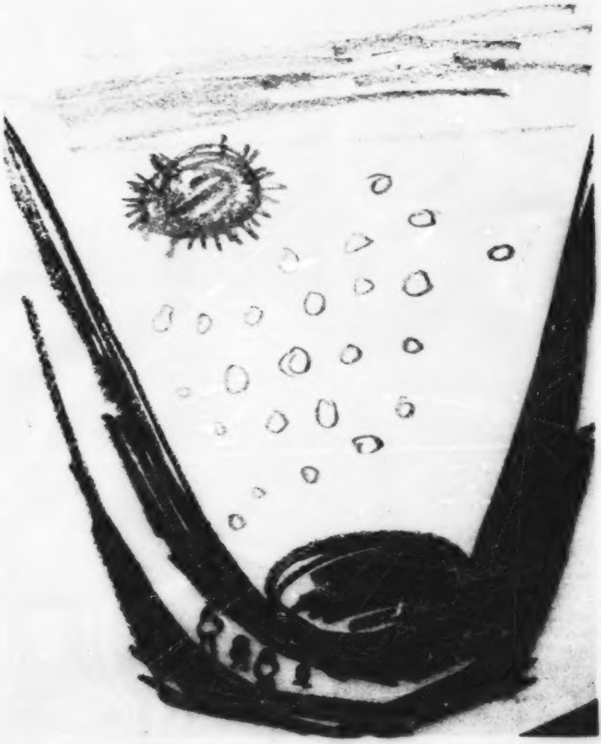


Fig. 3 *Drawing by eight-year-old girl brought to the hospital for vaginal bleeding. Father admitted molestation in the form of digital penetration. This drawing has similar composition and figure-ground to Figure 2 except for absence of teeth. The four figures on left represent the other family members who she described as being, "outside of the hot circle."*

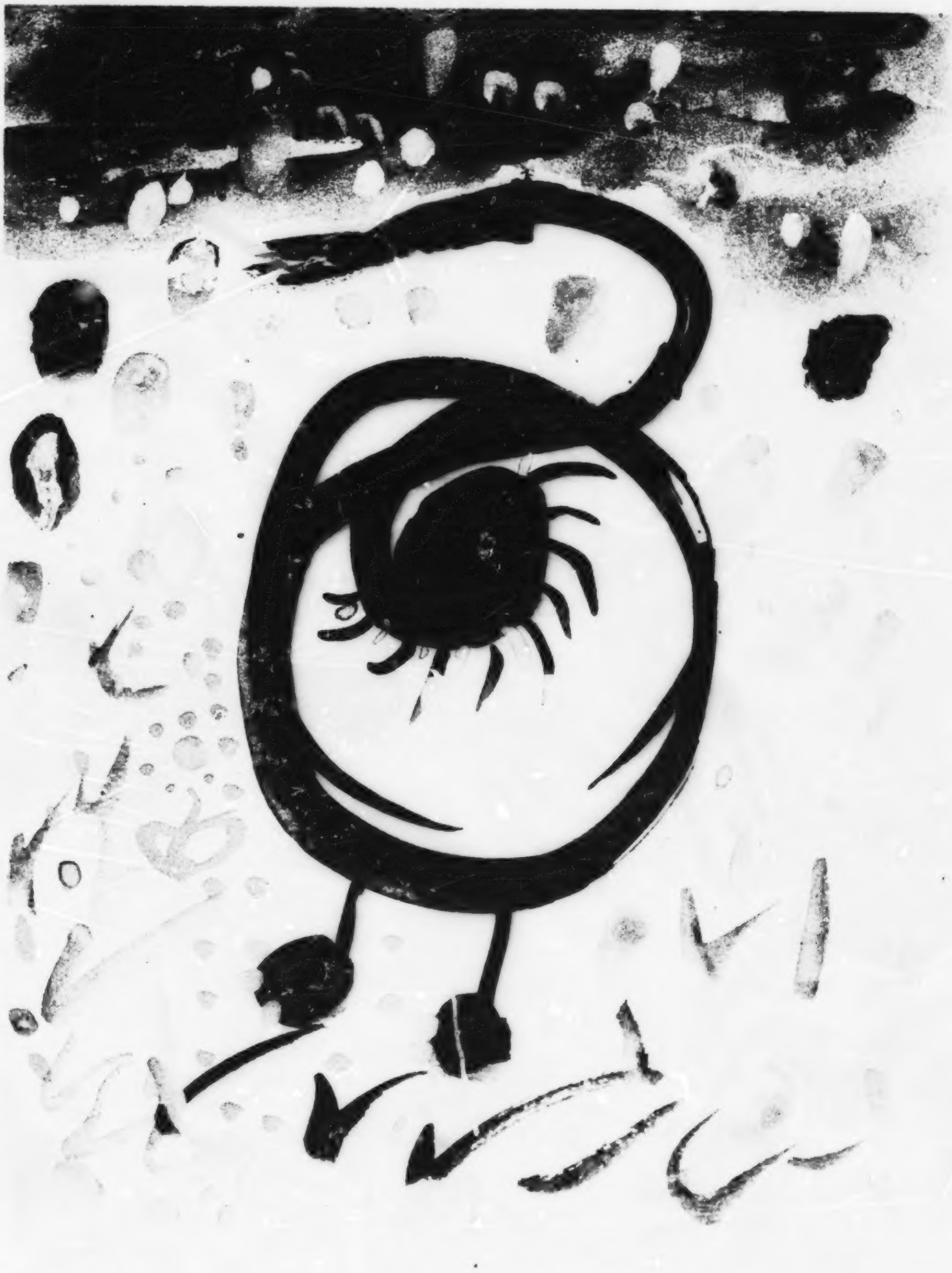


Fig. 4 *This picture developed from the Winnicott Squiggle exchange. The sexually abused adolescent saw "a fire-breathing snake about to hit someone." As with the child who drew Figure 10, she said that the eye represented herself, watching what was happening. The picture appears to be an expression of entrapment.*

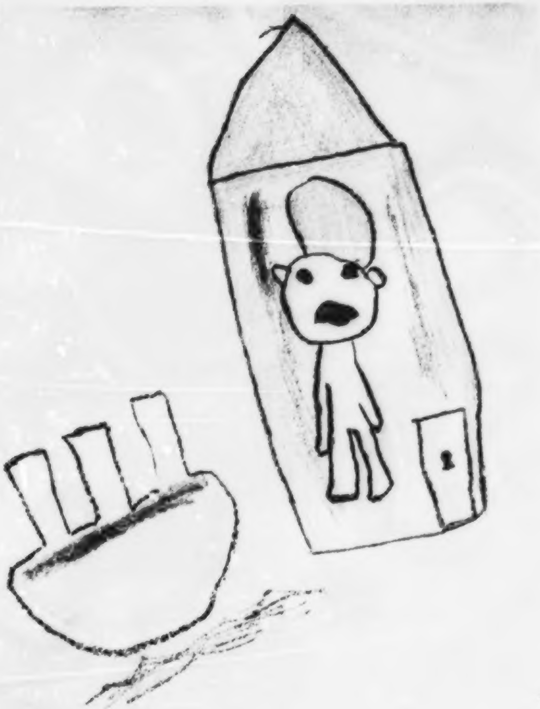
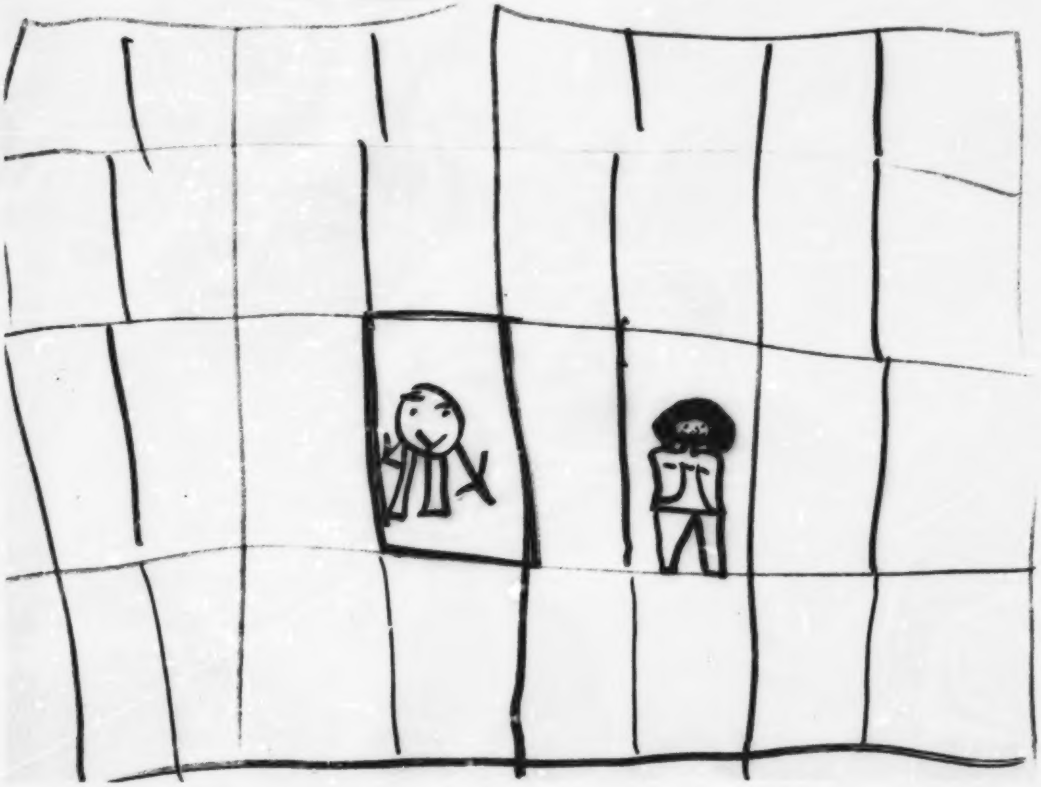


Fig. 5 & 6 *These two drawings by a sodomized seven-year-old boy tell of his struggle to visualize his father in jail. The frist drawing, done immediately after the arrest of his father, expresses some of the boy's fears about his father's confinement. He said the boat was included in the drawing, "so I can take my father away." Three months later, he was able to depict his father in a more realistic jail which even included a woman, "so that my father can have a friend in jail."*



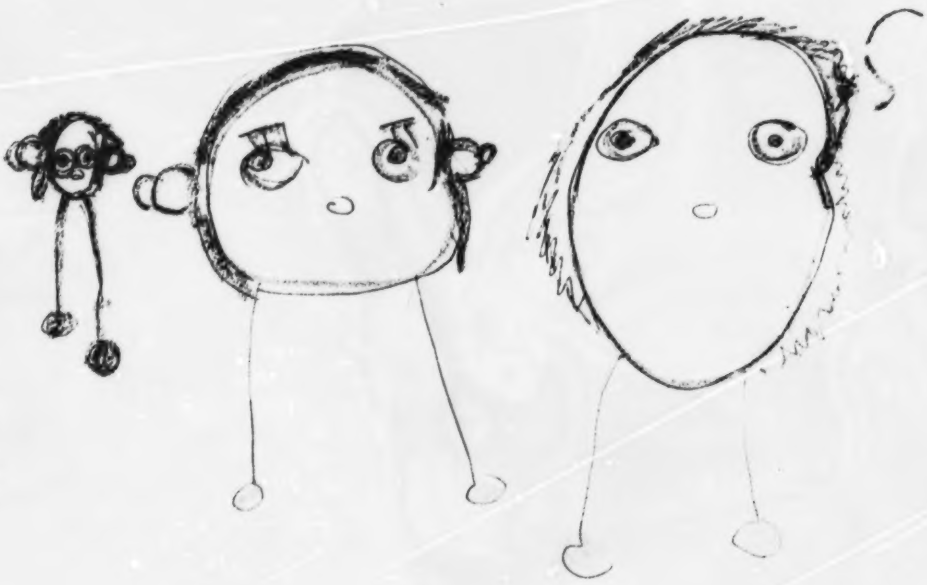
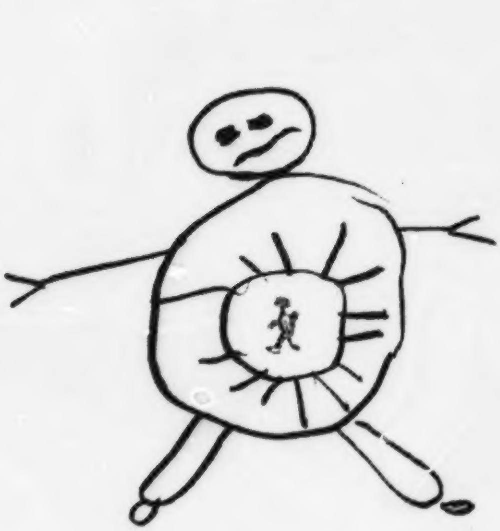


Fig. 7 *This is a free drawing created by a molested five-year-old during an art assessment interview. Previously, the child had been uncommunicative, and information about the case was incomplete. This drawing revealed that the child had been pressured by relatives not to talk to anyone about the incident.*



ig. 8 *An adolescent who had been impregnated by her father and then underwent an abortion exhibited a total inability to deal with body images, particularly the genitalia. This picture expresses her rejection of the violation of her body.*

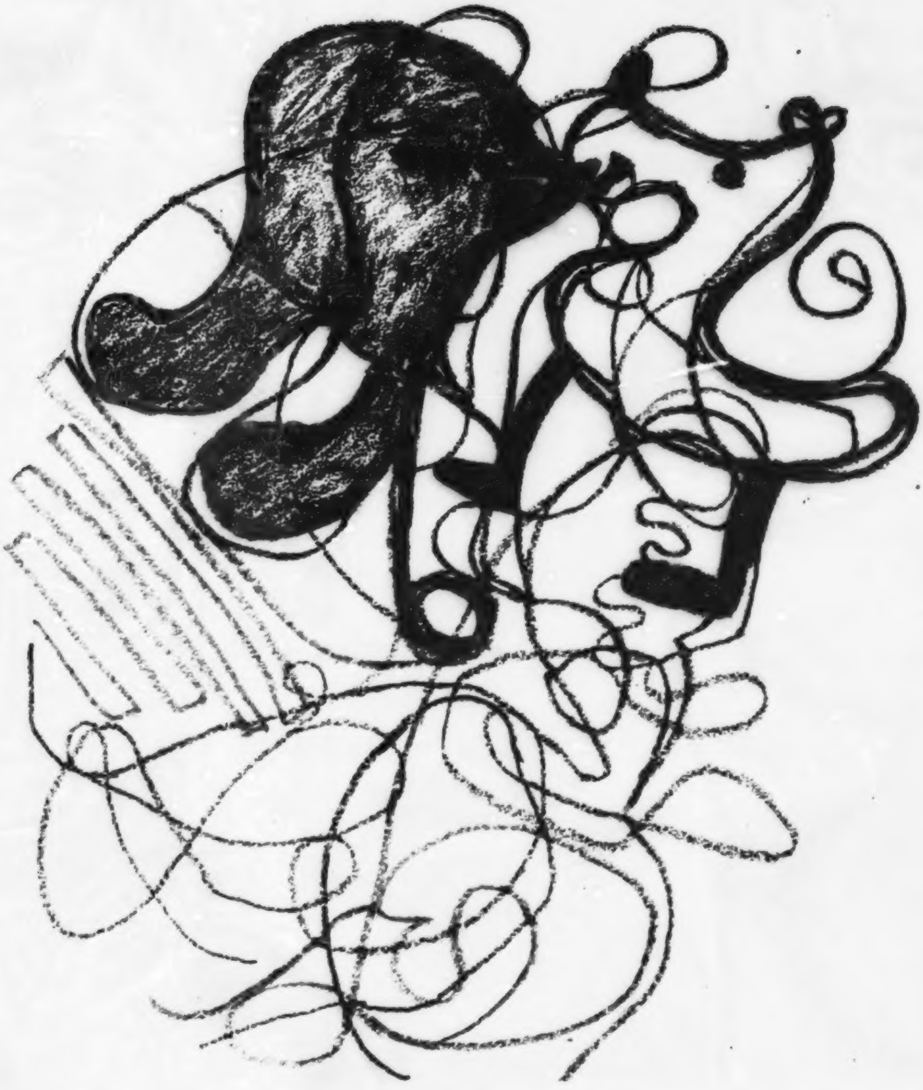


Fig. 9 *This picture, by a nine-year-old victim of non-familial rape was initiated through the use of the "scribble technique." The child said the picture looked like, "a monster kissing a girl." After completing this drawing, the child was able to make a statement acknowledging and describing the specifics of the rape.*

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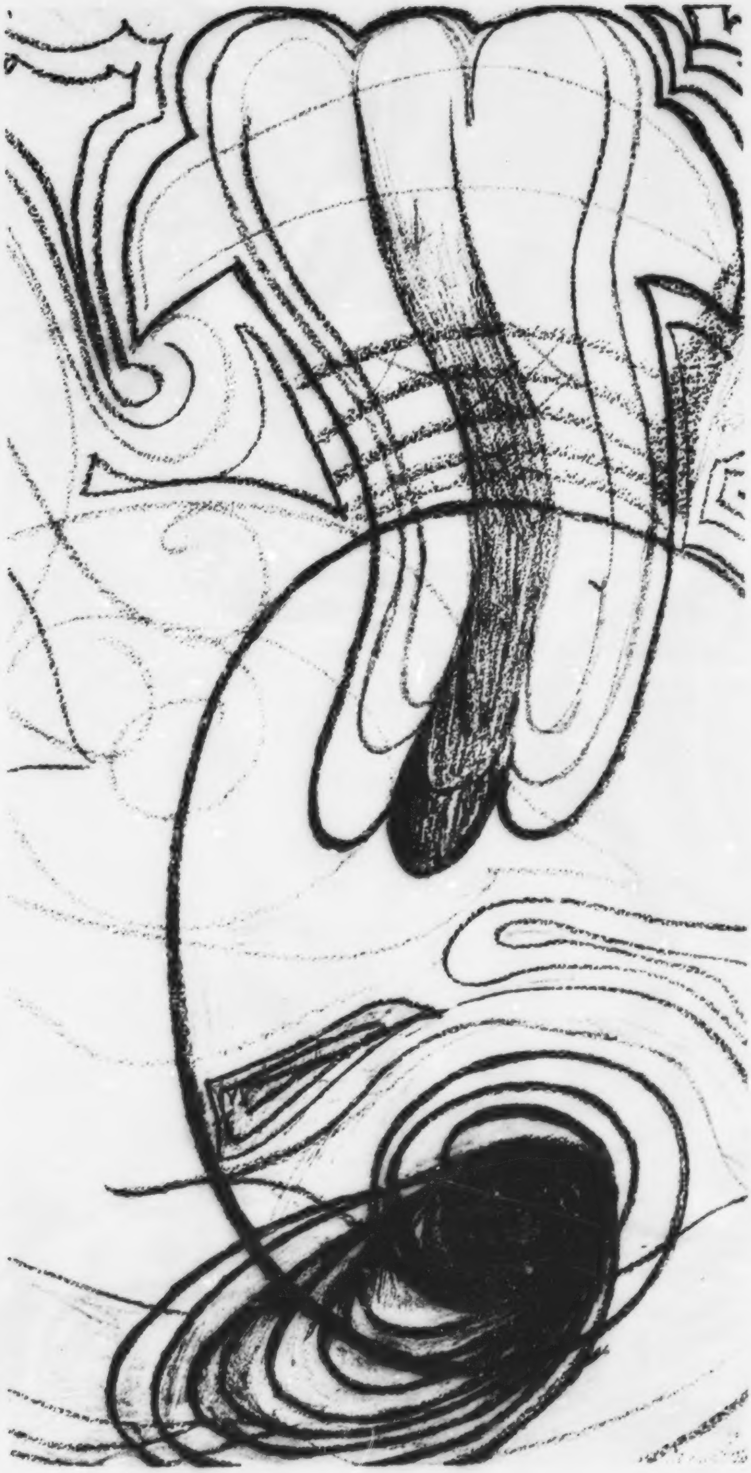

Fig. 10 *Section of a group scribble mural drawn by a latency-aged girl. Previously identified as a physically abused child, this drawing communicated either current or potential sexual molestation as well. Subsequent home investigation and her verbal communication ("That's me" – red eye at bottom – "and that's Jack's thing" – red-tipped projection from top –) demonstrated that her mother's boyfriend had been exposing himself to her and fondling her genitalia. One can see the original scribble lines and the way she emphasized the forms that were important to her.*

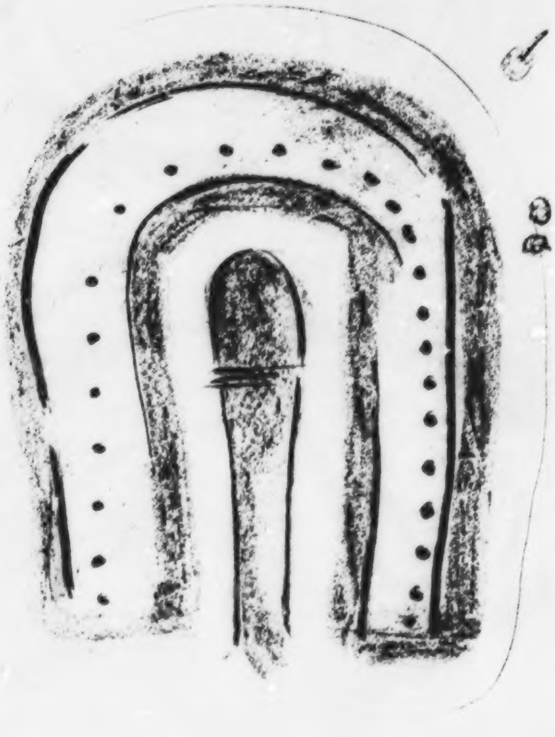

Fig. 11 *Painting by a girl who recently underwent an abortion after being impregnated by her stepfather. Her verbal reference was, "What I see in my sleep." This was the first expression of her fantasies about her abortion. The form suggests a bleeding ovoid or uterus and is very biological in affect.*

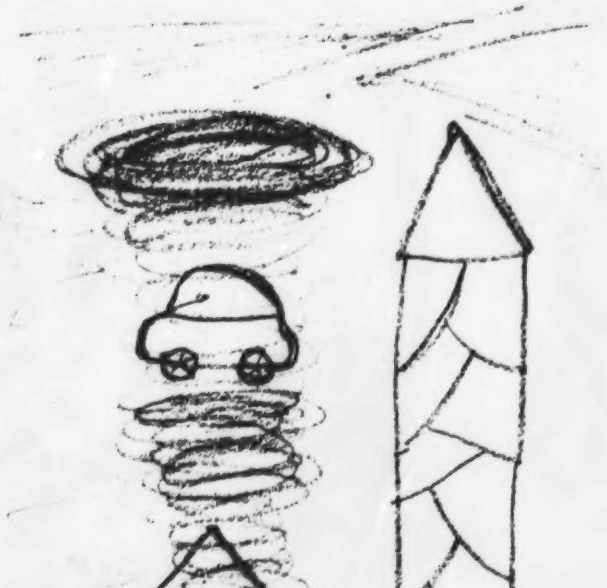

Fig. 12 *This is a drawing by a victim of stepfather-daughter incest which depicted the turmoil going on in her home following disclosure. After completing the drawing, she expressed her willingness to move to a foster home but stated that she wanted to maintain ties with her mother and siblings.*

# CHAPTER XII

# Art Therapy: A New Use in the Diagnosis and Treatment of Sexually Abused Children

Clara Jo Stember, A.T.R.

The purpose of this chapter is to outline how non-threatening art therapy can be used in the diagnosis and treatment of sexually abused children and how the art therapist can use creative expression to foster growth and integrate the trauma of child victims. Originally, this paper was prepared for the Connecticut State Child Sexual Abuse Conference, June, 1978, and, in part, it describes the art therapy component of the Sexual Trauma Treatment Pilot Program (STTPP), which is sponsored by the Connecticut Department of Children and Youth Services. STTPP, a demonstration project to identify effective ways of treating sexually abused children, is funded by the National Center on Child Abuse and Neglect. STTPP's art therapy component is an exploratory clinical investigation, as well as a more refined investigation of the mechanics of home service delivery and the integration of verbal and non-verbal disciplines. It is hoped that this discussion will stimulate further empirical investigations of graphic indicators helpful in preventive work with victims of child sexual abuse.

## Introduction

The development of the art therapist's theoretical and technical competence to effect therapeutic and creative change in children is a process that cannot be defined simply by listing the requisite skills, methods, or functions. Art therapy is a way of using art materials to help damaged people form a supportive alliance that permits expression of their emotions. The art therapist can help stabilize a temporarily disturbed development and help build self-confidence based upon existing strengths. Sexually abused children need appropriate ways to ventilate their anger, hostility, fear, and other feelings that may be inhibited or repressed. Painting the fantasies of the mind can be the first externalization, the first way of bringing the incident out (Fig. 1, 9, 11). This expression can help clear the way for healing and growth to occur.

Art therapy is growing as a discipline that combines the behavioral and psychological sciences with the many forms of the creative arts, such as music, movement, dance, and the visual arts. The President's Commission on Mental Health, in describing the arts as an aid in stressful situations, offers valuable observations: "Normal persons, children, who are involved in either personal or situational stress [such as sexual abuse] are temporarily vulnerable to developing emotional problems. The arts must be made available to these children to facilitate coping skills in the face of life-threatening trauma." [1]

The Sexual Trauma Treatment Pilot Program in Hartford, Connecticut, was designed to integrate non-verbal therapeutic techniques with more traditional clinical interventions by hiring a trained art therapist as a staff consultant. This specialist had clinical experience and was a certified teacher with training in pre-cognitive skill development through the arts. Staff training sessions were built into the program so that the art therapist had an opportunity to share skills and transmit information to other members of the treatment team.

Under the leadership of Suzanne Sgroi, M.D., and Norma Totah, M.S.W., chairman and vice-chairman of the pilot program, the art therapy module of the multidisciplinary STTPP team operates under a plan consisting of two separate but inter-dependent parts. Primary emphasis is on providing the services of the art therapist and any necessary materials to sexually abused children in their own homes. The involvement of the art therapist is designed to have a therapeutic impact on both the victim and the environment. Secondarily, the research component, designed as a case-by-case clinical investigation, is implemented through dated pictures of all art work done in art therapy sessions. Associated records are maintained, consisting of notations of process, children's verbal references, pivotal points of movement, and observable changes in art work and feelings.

The therapist's "Artmobile" contains a wide range of materials—paints, chalk, clay, and other media—to enable children to select the materials they need to best express their feelings and problems through art. The art work, coupled with non-threatening one-to-one attention, helps the children release feelings and conflicts and to grow emotionally. By talking to the parents, observing the home situation, and maintaining careful records of a child's interactions through art, the art therapist is able to help other team members tailor a treatment program for each child and family.

**Background**

Before we catalogue the theoreticians who have done and continue to do empirical as well as clinical investigations in this field, it is important to consider and *feel* the force of man's image-making nature.

Will you come with me now to a cave? Here a newly-erect Homo sapien is using the earth and his animals' blood to mark the place of his passing, what he did there, and something of his life and feelings. Feelings? Yes. The quality of line expresses his wonder at the grace and beauty of the other life that shares his space. The color, subtle and earthy, speaks of his sensitivity to the animals he draws. He places them high on the walls of his cave, their placement suggesting movement. How does he know to do these things? No one taught him. Early cave drawings are no accident. The aesthetics of their style, their authenticity, have been established. Ask then, "Why did he do that?" Do all of your answers come back to the basic knowledge of an inner force, a compulsion to make his mark? *The image making power of man's unconscious bypasses the verbal thinking which is still over-emphasized in our culture and education.*

During the 1920's and '30s, increasingly alert clinicians, primarily psychologists and psychiatrists, found symbolism and meaning in children's art work. They began building on early psychoanalytic investigations in an effort to identify commonalities in the art work of disturbed persons which could be useful for diagnosis. Dr. Lauretta Bender worked on the Bender (Visual Motor) Gestalt Test, using visual forms as diagnostic tools. Margaret Naumberg, working at the New York State Psychiatric Hospital and Columbia University, published her thoughts concerning a dynamically-oriented art psychotherapy. Her theoretical work evolved from the use of art therapy with impaired and hospitalized people. Her works, *Introduction To Art Therapy* and *Psychodynamically Oriented Art Therapy*, stand as the basis for the formulation of our present discipline.[2] Simultaneous with this development, Edith Kramer, a German artist living in Prague, began working with refugee children from Nazi Germany. When she came to the United States, she worked at the Wiltwyck School for Children and Albert Einstein Medical College. During this time, she developed her own thoughts on the use of art as therapy, as healer, and as teacher. Her thinking and clinical experience are contained in her book, *Art As Therapy With Children.*[3] Another art therapist, Rhoda Kellogg, has offered a systematic analysis of children's art work from a developmental perspective.[4] Dr. Joseph Di Leo has presented a synthesized study of children's art work and what it means to him.[5] Machover moved to a more precise empirical study of the meanings of lines, patterns, and shadings, as did Goodenough,[6] Betensky,[7] Kwiatkowska,[8] and Schildkraut.[9] Of these researchers, many are psychologists or psychiatrists, as well as Registered Art Therapists.

This background provides a perspective from which to view the contemporary emergence of art therapy. The American Art Therapy Association was incorporated in 1969. At present, there are over 500 Registered Art Therapists in the United States. Most work in hospital settings, many in clinics and day treatment programs. Others work in drug and alcohol abuse programs or in educational settings. Some are moving into the wider world of social services; still others are in private practice. As university-based programs expand, clinicians increasingly are combining research with teaching.

While there are many innovative and important developments in the field, such as Janie Rhyne's *Gestalt Art Experience,*[10] there are basically two major approaches represented among Registered Art Therapists. One stems from the psychodynamically-oriented art therapy of Naumberg, the other from a more pragmatic orientation based in art and education. A representative of the latter approach, Edith Kramer, expresses her philosophy this way: ". . . [by] using all the skills of an educator with professional skills in art combined with knowledge of normality and pathology in children, [art therapy] becomes primarily a means of supporting the ego, fostering growth through creative expression and the development of a sense of identity, in addition to promoting maturation in general." [11] Naumberg's psychodynamically-oriented art therapy is used to uncover unconscious material or interpret the meaning of symbolism. In this frame of reference, art therapy is a tool of psychiatry.

**Creating An Alliance**

Many contemporary art therapists work as I do, i.e., existentially: here/now. The focus is on where you are, where I am, what our space is, and where we can go. I start from where I am in my creative and life processes, using a wide variety of therapeutic systems and integrating them with my experience as an artist and a person. I deal, as Perls does in Gestalt Therapy, ". . . with what emerges." It is my goal to incorporate the humanistic tradition of the artist with the behavioral sciences. Dr. Bender points out that ". . . drawing is a piece of behavior." [12] The psychotherapist's way of understanding behavior may be verbal; my way is graphic (Fig. 2 & 3). I am concerned with authenticity, individuality, and self-actualization within the immediate life environment.

Language in our culture is loaded. It frequently encourages survival tactics that are destructive and unhealthy. Art expression is a non-threatening approach. For deeply hurt people, protection of feelings is often necessary. By accepting this fact, the art therapist can help others see feelings in drawing without otherwise demanding that the patient/client reveal the hurt. In this way, the art work acts as a vehicle for pulling together feelings and expression.

The art therapist has a profound respect for process, a lack of repressive rules, and an acceptance of person and work. An example of one way a therapist may work, whether the goal is assessment, diagnosis, or initiation of treatment, is the simple Winnicott Squiggle game (Fig. 4).[13] With this method, the child chooses a drawing instrument, and the therapist chooses a contrasting one. Vocabulary is simple and direct: "I'm going to close my eyes and make a little squiggle on the paper; then, you can make it into a picture." The therapist then might suggest that the child tell a little about what she or he has drawn, providing some prompting, if necessary, by wondering aloud about what is happening in the picture, what might happen, etc. The procedure is then reversed, with the child drawing the squiggle and the therapist completing the picture.

The structure of this exchange reflects a basic issue which relates to all psychotherapeutic interactions: establishing contact and initiating rapport. Like many art therapy activities, this is a process without rules, except, of course, for the primary ones of therapeutic exchange. First, the child is given permission for spontaneous and active participation. Second, based on the child's picture (or his or her refusal to draw one), the therapist actively joins in an exchange through the picture he or she creates in turn. Consolidation of the relationship occurs through this flow, and reciprocity grows.

In other parts of the session, the therapist assumes an observational posture. The therapist can be a real person with the child, not forced into role playing, as with puppets or dolls. While play therapy can be invaluable, it is necessary to transcend this level of fantasy to reach truly expressive work that can foster growth, rehabilitation, and re-integration of a damaged ego. Another consideration here is that the therapist can let the child know what he or she thinks. Although no actual diagnostic information is shared with the victim, a child can be helped to clarify problems through visual representations. Such visual exchange protects against some of the turmoil that can result from direct confrontation.

The projective elements in children's creations represent their concerns, while, at the same time, presenting the therapist with an idea of how they are organizing or dealing with their internal anxieties (as opposed to how these anxieties are disorganizing them). The therapist can gather clues from children's drawings by observing the placement of images on the paper and the organization of line and form. These elements indicate how children are using, modifying, or structuring some of their concerns. (Fig. 5 and 6) Levels of anxiety can be observed within this reassuring context. For example, more elaborate drawings often signal a decrease in anxiety.

Withdrawal from any expression sometimes occurs after a child has produced a particularly revealing drawing. This was the case with Caren who had been aborted of a fetus impregnated by her father. Both sisters in this family had been molested by their father. He had been jailed; the mother was divorc[illegible] him; and Caren's world was in chaos. Her school grades [illegible] she avoided most of her friends; and she was blamed by her relatives. She felt ashamed and distraught. I went to her home for a regularly scheduled art therapy session and introduced a free, wet wash technique using water colors. Caren d[illegible] expressive painting after many stereotyped drawin[illegible] titled it "Ribbons and Worms", she immedia[illegible] back into her shell and continued to draw and say the rigid, unrevealing things she had provided before this one expressive painting. This often happens when a child is severely traumatized and unable to face the fact of the molestation. This is also a clue to the existence of a common phenomenon: the merging of self with the sexual molestation. In this case, Caren was unable to separate herself from the overwhelming effects of the betrayal by her parents, the violation of her body, and her own shame. She needed to hide. It is likely that it will take a long time for her to pull her life together and find out who Caren is now.

With children like Caren, who are severely traumatized and withdrawn, I have found the Ulman-Levy Diagnostic Test valuable in assessing strengths.[14] This instrument consists of a series of structured and free drawings that offers the child an opportunity to demonstrate abilities to incorporate new skills. Often, children find the exercise reassuring, and it offers important indicators for the art therapist. This series provided particularly useful information with Carol, whose last free drawing showed enough confidence to communicate the fact that she had been told not to talk about the molestation with me or "any other of those people." (Fig. 7)

All art therapists must be able to design activities that will foster growth, offer information, or reveal the emotional state and personal conflicts of the child in question. An art background is essential. The therapist must be in full control of the medium being used. For example, John, sodomized by his father at the age of seven, was on the verge of exploding with hate. His father had been arrested; his family was shattered. He also was grieving over the loss of his father. (Fig. 5 and 6) He needed a way to channel these hot feelings. The art therapist knows that clay is a great material for ventilation. Pounding and wedging to get the air bubbles out is concrete activity; kneading and pulling and smashing the clay help provide a focus for pent-up emotions. But when the wild catharsis turns to the creation of form, the artist must know how to keep the evolving object intact. If, for instance, lack of knowledge about the proper consistency of clay causes the work to fall apart as it dries, the mastery, gratification, and good feelings about having created something can be destroyed. This type of negative experience may only reinforce what the child already thinks about himself. If our goal is to help children gain control over their own actions, and the products of their artistic efforts are proof of this growing skill, then their works must be sound.

### Integrating an Art Therapy Component

Solutions to the problems arising from efforts to integrate verbal and non-verbal disciplines require flexibility and an exploratory attitude on the part of all professionals who work on the team. If professional staff can be successfully integrated, a comprehensive network emerges that is organized around the goals of re-integrating child victims of sexual assault and helping them rebuild their lives. STTPP's art therapy component was designed to permit both autonomy and integration. It was decided that this component should be housed in an "Artmobile" to ensure mobility and accessibility. In this way, the therapist and a wide range of materials can be made available to children in their own homes or in foster homes in those cases in which outside placement is necessary.

In practice, this means that the art therapist designs clinical investigation instruments that serve both as therapeutic tools and as a means of contributing to the growing body of case information. Pictorial records of individual movements combine with the results of psychological evaluation and medical and social service work-ups. The art therapist is an integral part of all phases, participating in case conferences and multidisciplinary staff review meetings where all team members add pieces to the diagnostic puzzle. As the pieces fit together, staff proceed with the treatment planning and the maintenance of problem-oriented records necessary for total impact evaluation. For example, as the issues surrounding a specific, dysfunctional, incestuous family are identified and clarified, directional planning by the team becomes more focused. Frequently, the art therapist, working in the home, has an opportunity to observe directly what really happens between parents and child. This information can be crucial to the total planning process.

The art therapist also is available to all team members for art assessment interviews. When ambiguity or withdrawal are severe, and the core therapist feels that the victim is in need of expressing feelings or information, art therapy can be effective in helping the child release pent-up emotions (Fig. 1, 8, 9). The degree of amenability of a child victim to treatment via nonverbal expression may be determined by the treatment team, or, on an emergency basis, by an individual therapist. Scheduling is worked out by all the therapists involved with the case, as well as by the victim and family. Because the sexually abused child is the primary focus of the art therapy service, many other forms of treatment also may be initiated as members of the family signal their readiness. Mother-daughter dyads may evolve, as well as couples counseling and family therapy.

While any or all of these treatment approaches are in progress, the art therapist remains available to respond to whatever emerges. For example, a therapist may be working with a child victim of non-familial rape whose family appears to be functioning supportively. However, the therapist discovers that substantial problems in communication among family members are the reason why the child was unable to tell her mother about the assault until two months after it occurred. In such a case, the art therapist is able to offer the family a unique way—through family art therapy—to share feelings and learn a new method of talking to each other. The therapist approaches group work and re-socialization through non-threatening, non-directive group murals and mutual planning of art projects that help establish responsibility as well as individual limits. An art mural, kinetic in subject, might be selected as a way of allowing family members to see what they are doing. (Fig. 10) This can become a new way to share pleasure, laughter, and insights.

The pictures included in this paper are all children's art work done in art therapy sessions. They are representative of art work done by the STTPP population, with cases ranging from pediatric venereal disease to adolescent pregnancy resulting from father-daughter incest. The variables of these forms will become meaningful to the reader as they are related to the story of the child. Let yourself synthesize your responses; you may find the commonalities and the individual differences.

### Identity in Turmoil

The inner turmoil and conflict of many sexually abused children is directly responsive to art therapy. Not only is art healing in itself, but, since the trauma of sexual abuse is usually primarily psychological, art work can provide a vehicle for bringing even deeply repressed trauma to the surface where it can be balanced with the outer world. Many child victims suffer intense conflict and confusion in trying to disentangle their former sense of themselves—their self-identities—from their experiences with sexual abuse. They often become lost in swirls of anguish as they try to find a sense of themselves separate from the violated forms of their bodies (Fig. 7, 8). To rebuild the self as separate from the incident takes different lengths of time. The length of recovery time appears to be correlated with the point of development the abuse interrupted, the length and severity of the abuse, and the character of the victim. Individuality in victims of sexual abuse appears to override commonalities of symbolism.

During latency and adolescence, the variables identified by Dr. Ann Burgess are expressed in art work more frequently than universal symbols.[15] The most powerful and frequent expressions are of low self-esteem, guilt, and bewilderment. In keeping with Dr. Burgess's descriptions, there are clear expressions of the immediate diffusion of personality after a sexual assault. However, evidence of the re-integration process begins to appear in drawings only as personality and behavior respond to integrating treatment. Shame often appears to be concealed behind clown symbols. This concealment device appears frequently among severely hurt girls who are maintaining a facade of smiling exuberance or who are involved in hostile acting out. Therapists must be alert to such expressions of distress, not only because they often signal disturbances associated with premature sexual experience, but also because the developing negative self-image may solidify and be perpetuated unless therapeutic intervention is provided. Opportunities for developing and expressing a separation of self from incident must be built into art therapy sessions.

Dr. Diane Browning points out the need to deal with the immediate trauma of incest rather than to concentrate on its consequences.[16] The wide spectrum of reactions between girls who have had protective intervention immediately, and those for whom intervention was delayed is clearly revealed in their ability to express themselves through art therapy. For example, Lynn, whose impregnation by her stepfather was terminated early, received immediate crisis counseling. Her totally dysfunctional family was moved into a closely monitored setting, and she was separated from the perpetrator. Within a short time, she was able to paint a large, overwhelming form of the fantasy that had dominated her since the abortion (Fig. 11). Soon after this primary externalization, she was able to work a very small version of the same form in clay. This reduction of the image to a manageable size was begun when she confronted what she had created in the large painting. As she finished the clay model, she placed herself with her back to the painting. After this, she was able to verbalize her experiences in the adolescent group meetings. Her progress has been a continuum of integration, in spite of the fact that her stepfather returned home and began molesting her again. This made it necessary to move her to a foster home. However, she has been able to express her continuing need for her STTPP network. The core therapist and art therapist continue to work with her. For this child, the length and severity of disturbing after-effects of sexual molestation appear to have been shortened as a result of early intervention.

Contrast Lynn's ability to use the STTPP network with that of Kara, who did not receive immediate intervention and who still is relatively unable to use the team. Like Lynn's, Kara's experience with sexual abuse was long and accelerated over time. She was impregnated by her father, and he was arrested. She was blamed by family members, who tried to keep the entire episode a secret. These obstacles and delays prevented Kara from using the services available to her. Her anxiety, acting out, failure in school, and withdrawal from friends were clearly visible. Although she was offered outlets through art therapy and group work with other adolescents, she was unable to use these avenues to express her fear and hostility toward her mother, who had failed to protect her, or her love/hatred for her father, who had violated and betrayed her. Kara's drawings are tight, rigid, and immature. Apparently, she views this tight control as a necessary survival tactic. As the changes in her life pour over her, she is withdrawing more and more.

Lynn, on the other hand, was even able to express the recurrence of sexual approaches by her stepfather, a painful reality for her to face. She was able, through painting, to externalize her mixed feelings about moving to a foster home, i.e., wanting to be able to see her mother and sisters, even though the chaos in her home was worsening (Fig. 12). After her move, she began singing while she painted. Her last painting was the largest she had ever dared. It is entitled "Downtown," and she verbally expressed a wish "to go there sometime." This indicated new self-confidence, a willingness to take risks, and a stretching of her vision of the world.

Dr. Sgroi stresses that professionals must guard against misinterpreting behavioral signs when assessing whether or not child sexual abuse has actually occurred.[17] This care must be doubled for the art therapist, who at all times must balance projective assumptions with data-based information. It also is critical to evaluate all self-appointed therapists, as there are some untrained, inexperienced people who present themselves as art therapists. The American Art Therapy Association can be contacted concerning professional requirements and standards.* The need for painstaking care and expertise is illustrated by a recent case seen by the STTPP team. Initially, the team received incomplete information on a reported case of possible sexual abuse; however, the child's first spontaneous drawing gave no indication of any assault. In such situations, it is essential that creative activities be designed to further clinical investigation. Through pictorial records of the child's next work, her verbal references, and, finally, confirmation by her mother, it was discovered that the girl was doing what her mother and older sister did. They all were pleasurably involved in sexual activity. In this instance, graphic productions were indicators of reasonable doubt of forcible assault.

## Conclusion

This clinical sampling tends to confirm our hypothesis that art therapy can serve as an effective treatment modality, as well as a unique tool for therapeutic interviewing and assessment. There is cumulative evidence that sharing art therapy skills with a multidisciplinary team offers additional diagnostic tools for verbal therapy with sexually abused children. This is not surprising when one considers the goals shared by art therapists and other professionals involved in therapeutic interactions with sexually abused children. We all are interested in providing support, guidance, help in resolving conflicts, enhancement of maturation, and assistance in moving through a rough patch. For sexually abused children and adolescents, these all are elements needed to rebuild damaged self-esteem and re-integrate a shattered ego. We all need tools for handling hostility, as well as for meeting dependency needs. We all need tools to help us establish limits and develop impulse controls. We all need ways to try out new skills and work through new and difficult relationships or problems. Art therapists have effective techniques for working toward these goals. For some victims, this may be the route to health, for others it may not. However, from the perspective of my work, these goals, these techniques, these elements add up to a supportive, insightful, rehabilitating experience that permits many sexually abused children to get on with the task of learning how to live.

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# CHAPTER XIII

# Father-Daughter Incest

Judith Herman, M.D., and Lisa Hirschman, M.A., M.Ed.

The incest taboo is universal in human culture. Though it varies from one culture to another, it is generally considered by anthropologists to be the foundation of all kinship structures. Levi-Strauss describes it as the basic social contract; Mead says its purpose is the preservation of the human social order.[1] All cultures, including our own, regard violations of the taboo with horror and dread. Death has not been considered too extreme a punishment in many societies. In our laws, some states punish incest by up to twenty years' imprisonment.[2]

In spite of the strength of the prohibition on incest, sexual relations between family members do occur. Because of the extreme secrecy which surrounds the violation of our most basic sexual taboo, we have little clinical literature and no accurate statistics on the prevalence of incest. This paper attempts to review what is known about the occurrence of incest between parents and children, to discuss common social attitudes which pervade the existing clinical literature, and to offer a theoretical perspective which locates the incest taboo and its violations within the structure of patriarchy.

### The Occurrence of Incest

The Children's Division of the American Humane Association estimates that a minimum of 80,000-100,000 children are sexually molested each year.[3] In the majority of these cases the offender is well known to the child, and in about 25 percent of them, a relative. These estimates are based on New York City police records and the experience of social workers in a child protection agency. They are, therefore, projections based on observing poor and disorganized families who lack the resources to preserve secrecy. There is reason to believe, however, that most incest in fact occurs in intact families and entirely escapes the attention of social agencies. One in sixteen of the 8,000 white, middle-class women surveyed by Kinsey, et al, reported sexual contact with an adult relative during childhood.[4] In the vast majority of these cases, the incident remained a secret.

A constant finding in all existing surveys is the overwhelming predominance of father-daughter incest. Weinberg, in a study of 200 court cases in the Chicago area, found 164 cases of father-daughter incest, compared with two cases of mother-son incest.[5] Maisch, in a study of court cases in the Federal Republic of Germany, reported that 90 percent of the cases involved fathers and daughters, step-fathers and step-daughters, or (infrequently) grandfathers and granddaughters.[6] Fathers and sons accounted for another 5 percent. Incest between mothers and sons occurred in only 4 percent of the cases. Incest appears to follow the general pattern of sexual abuse of children, in which 92 percent of the victims are female, and 97 percent of the offenders are male.[7]

It may be objected that these data are all based on court records and perhaps reflect only a difference in complaints rather than a difference in incidence. The Kinsey reports, however, confirm the impression of a major discrepancy between the childhood sexual contacts of boys and girls. If, as noted above, more than 6 percent of the female sample reported sexual approaches by adult relatives, only a small number of the 12,000 men surveyed reported sexual contact with any adult, relative or stranger. (Exact figures were not reported.) Among these few, contact with adult males seemed to be more common than with adult females. As for mother-son incest, the authors concluded that "heterosexual incest occurs more frequently in the thinking of clinicians and social workers than it does in actual performance." [8] None of the existing literature, to our knowledge, makes any attempt to account for this striking discrepancy between the occurrence of father-daughter and mother-son incest.

### Common Attitudes toward Incest in the Professional Literature

Because the subject of incest inspires such strong emotional responses, few authors have even attempted a dispassionate examination of its actual occurrence and effects. Those who have approached the subject have often been unable to avoid defensive reactions such as denial, distancing, or blaming. We undertake this discussion with the full recognition that we ourselves are not immune to these reactions, which may be far more apparent to our readers than to ourselves.

Undoubtedly the most famous and consequential instance of denial of the reality of incest occurs in Freud's 1897 letter to

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**The authors gratefully acknowledge the contributions of the incest victims themselves and of the therapists who shared their experience with us. For reasons of confidentiality, we cannot thank them by name.**

Fliess. In it, Freud reveals the process by which he came to disbelieve the reports of his female patients and develop his concepts of infantile sexuality and the infantile neurosis: "Then there was the astonishing thing that in every case blame was laid on perverse acts by the father, and realization of the unexpected frequency of hysteria, in every case of which the same thing applied, though it was hardly credible that perverted acts against children were so general." [9]

Freud's conclusion that the sexual approaches did not occur in fact was based simply on his unwillingness to believe that incest was such a common event in respectable families. To experience a sexual approach by a parent probably *was* unlikely for a boy: Freud concluded incorrectly that the same was true for girls. Rather than investigate further into the question of fact, Freud's followers chose to continue the presumption of fantasy and made the child's desire and fantasy the focus of psychological inquiry. The adult's desire (and capacity for action) were forgotten. Psychoanalytic investigation, then, while it placed the incest taboo at the center of the child's psychological development, did little to dispel the secrecy surrounding the actual occurrence of incest. As one child psychiatrist commented: "Helene Deutsch and other followers of Freud have, in my opinion, gone too far in the direction of conceptualizing patients' reports of childhood sexual abuse in terms of fantasy. My own experience, both in private practice and with several hundred child victims brought to us . . . [at the Center for Rape Concern] . . . in Philadelphia, has convinced me that analysts too often dismissed as fantasy what was the real sexual molestation of a child . . . As a result, the victim was isolated and her trauma compounded." [10]

Even those investigators who have paid attention to cases of actual incest have often shown a tendency to comment or make judgments concerning the guilt or innocence of the participants. An example:

> *These children undoubtedly do not deserve completely the cloak of innocence with which they have been endowed by moralists, social reformers, and legislators. The history of the relationship in our cases usually suggests at least some cooperation of the child in the activity, and in some cases the child assumed an active role in initiating the relationship . . . It is true that the child often rationalized with excuses of fear of physical harm or the enticement of gifts, but these were obviously secondary reasons. Even in the cases where physical force may have been applied by the adult, this did not wholly account for the frequent repetition of the practice.*
>
> *Finally, a most striking feature was that these children were distinguished as unusually charming and attractive in their outward personalities. Thus, it was not remarkable that frequently we considered the possibility that the child might have been the actual seducer, rather than the one innocently seduced.*[11]

In addition to denial and blame, much of the existing literature on incest shows evidence of social and emotional distancing between the investigators and their subject. This sometimes takes the form of an assertion that incestuous behavior is accepted or condoned in some culture other than the investigator's own. Thus, a British study of Irish working-class people reports that father-daughter incest, which occurred in 4 percent of an unselected outpatient clinic population, was a "cultural phenomenon" precipitated by social isolation or crowding, and had "no pathological effects." [12] The several investigators who have also reported instances where children, in their judgment, were not harmed by the incest experience do not usually state the criteria on which this judgment is based.[13] Still other investigators seem fearful to commit themselves to an opinion on the question of harm. Thus, for example, although 70 percent of the victims in Maisch's survey showed evidence of disturbed personality development, the author is uncertain about ascribing this to the effects of incest per se.

A few investigators, however, have testified to the destructive effects of the incest experience on the development of the child. Sloane and Karpinski, who studied five incestuous families in rural Pennsylvania, conclude: "Indulgence in incest in the post-adolescent period leads to serious repercussions in the girls, even in an environment where the moral standards are relaxed." [14] Kaufman, Peck, and Tagiuri, in a thorough study of eleven victims and their families who were seen at a Boston clinic, report: "Depression and guilt were universal as clinical findings. . . . The underlying craving for an adequate parent . . . dominated the lives of these girls." [15]

Several retrospective studies, including a recent report by Benward and Densen-Gerber, document a strong association between reported incest history and the later development of promiscuity or prostitution.[16] In fact, failure to marry or promiscuity seems to be the only criterion generally accepted in the literature as conclusive evidence that the victim has been harmed.[17] We believe that this finding in itself testifies to the traditional bias which pervades the incest literature.

Our survey of what has been written about incest, then, raises several questions. Why does incest between fathers and daughters occur so much more frequently than incest between mothers and sons? Why, though this finding has been consistently documented in all available sources, has no previous attempt been made to explain it? Why does the incest victim find so little attention or compassion in the literature, while she finds so many authorities who are willing to assert either that the incest did not happen, that it did not harm her, or that she was to blame for it? We believe that a feminist perspective must be invoked in order to address these questions.

### Incest and Patriarchy

In a patriarchal culture, such as our own, the incest taboo must have a different meaning for the two sexes and may be observed by men and women for different reasons.

Major theorists in the disciplines of both psychology and anthropology explain the importance of the incest taboo by placing it at the center of an agreement to control warfare among men. It represents the first and most basic peace treaty. An essential element of the agreement is the concept that women are the possessions of men; the incest taboo represents an agreement as to how women shall be shared. Since virtually all known societies are dominated by men, all versions of the incest taboo are agreements among men regarding sexual access to women. As Mitchell points out, men create rules governing the exchange of women; women do not create rules governing the exchange of men.[18] Because the taboo is created and enforced by men, we argue that it may also be more easily and frequently violated by men.

The point at which the child learns the meaning of the incest taboo is the point of initiation into the social order. Boys and girls, however, learn different versions of the taboo. To paraphrase Freud once again, the boy learns that he may not consummate his sexual desires for his mother because his mother belongs to his father, and his father has the power to inflict the most terrible of punishments on him: to deprive him of his maleness.[19] In compensation, however, the boy learns that when he is a man he will one day possess women of his own.

When this little boy grows up, he will probably marry and may have a daughter. Although custom will eventually oblige him to give away his daughter in marriage to another man (note that mothers do not give away either daughters or sons), the taboo against sexual contact with his daughter will never carry the same force, either psychologically or socially, as the taboo which prohibited incest with his mother. *There is no punishing father to avenge father-daughter incest.*

What the little girl learns is not at all parallel. Her initiation into the patriarchal order begins with the realization that she is not only comparatively powerless as a child, but that she will remain so as a woman. She may acquire power only indirectly, as the favorite of a powerful man. As a child she may not possess her mother *or* her father; when she is an adult, her best hope is to be possessed by someone like her father. Thus, according to Freud, she has less incentive than the boy to come to a full resolution of the Oedipus complex.[20] Since she has no hope of acquiring the privileges of an adult male, she can neither be rewarded for giving up her incestuous attachments, nor punished for refusing to do so. Chesler states the same conclusion more bluntly: "Women are encouraged to commit incest as a way of life . . . As opposed to marrying our fathers, we marry men like our fathers . . . men who are older than us, have more money than us, more power than us, are taller than us, are stronger than us . . . our fathers." [21]

A patriarchal society, then, most abhors the idea of incest between mother and son, because this is an affront to the father's prerogatives. Though incest between father and daughter is also forbidden, the prohibition carries considerably less weight and is, therefore, more frequently violated. We believe this understanding of the asymmetrical nature of the incest taboo under patriarchy offers an explanation for the observed difference in the occurrence of mother-son and father-daughter incest.

If, as we propose, the taboo on father-daughter incest is relatively weak in a patriarchal family system, we might expect violations of the taboo to occur most frequently in families characterized by extreme paternal dominance. This is in fact the case. Incest offenders are frequently described as "family tyrants." "These fathers, who are often quite incapable of relating their despotic claim to leadership to their social efforts for the family, tend toward abuses of authority of every conceivable kind, and they not infrequently endeavor to secure their dominant position by socially isolating the members of the family from the world outside. Swedish, American, and French surveys have pointed time and again to the patriarchal position of such fathers, who set up a 'primitive family orders'. " [22] Thus the seduction of daughters is an abuse which is inherent in a father-dominated family system; we believe that the greater the degree of male supremacy in any culture, the greater the likelihood of father-daughter incest.

A final speculative point: since, according to this formulation, women neither make nor enforce the incest taboo, why is it that women apparently observe the taboo so scrupulously? We do not know. We suspect that the answer may lie in the historic experience of women both as sexual property and as the primary caretakers of children. Having been frequently obliged to exchange sexual services for protection and care, women are in a position to understand the harmful effects of introducing sex into a relationship where there is a vast inequality of power. And, having throughout history been assigned the primary responsibility for the care of children, women may be in a position to understand more fully the needs of children, the difference between affectionate and erotic contact, and the appropriate limits of parental love.

## A Clinical Report

The following is a clinical case study of fifteen victims of father-daughter incest. All the women were clients in psychotherapy who reported their incest experiences to their therapists after the fact. Seven were women whom the authors had personally evaluated or seen in psychotherapy. The remaining eight were clients in treatment with other therapists. No systematic case-finding effort was made; the authors simply questioned those practitioners who were best known to us through an informal network of female professionals. Four out of the first ten therapists we questioned reported that at least one of her clients had an incest history. We concluded from this admittedly small sample that a history of incest is frequently encountered in clinical practice.

Our combined group of six therapists (the authors and our four informants) had interviewed close to 1,000 clients in the past five years. In this population, the incidence of reported father-daughter incest was 2-3 percent. We believe this to be a minimum estimate since in most cases no particular effort was made to elicit the history. Our estimate accords with the data of the Kinsey report, [23] in which 1.5 percent of the women surveyed stated that they had been molested by their fathers.

For the purposes of this study, we defined incest as overt sexual contact such as fondling, petting, masturbation, or intercourse between parent and child. We included only those cases in which there was no doubt in the daughter's mind that explicit and intentionally sexual contact occurred and that secrecy was required. Thus we did not include in our study the many women who reported seductive behaviors such as verbal sharing of sexual secrets, flirting, extreme possessiveness or jealousy, or intense interest in their bodies or their sexual activities on the part of their fathers. We recognize that these cases represent the extreme of a continuum of father-daughter relationships which range from the affectionate through the seductive to the overtly sexual. Information about the incest history was initially gathered from the therapists. Those clients who were willing to discuss their experiences with us in person were then interviewed directly.

The fifteen women who reported that they had been molested during childhood were, in other respects, quite ordinary women. Nothing obvious distinguished them from the general population of women entering psychotherapy (see table 1). They ranged in age from fifteen to fifty-five. Most were in their early twenties at the time they first requested psychotherapy. They were all white. Four were single, seven married, and four separated or divorced. Half had children. The majority had at least some college education. They worked at common women's jobs: housewife, waitress, factory worker, office worker, prostitute, teacher, nurse. They complained mostly of depression and social isolation. Those who were married or recently separated complained of marital problems. The severity of their complaints seemed to be related to the degree of family disorganization and deprivation in their histories rather than to the incest history per se. Five of the women had been hospitalized at some point in their lives; three were or had been actively suicidal, and two were addicted to drugs or alcohol. Seven women brought up the incest history among their initial complaints; the rest revealed it only after having established a relationship with the therapist. In some cases, the history was not disclosed for one, two, or even three years after therapy had begun.

## TABLE 1

**Characteristics of Incest Victims**
**Entering Therapy**

| Characteristic | Victims (N) |
|---|---|
| **Age (years):** | |
| 15-20 | 3 |
| 21-25 | 7 |
| 26-30 | 2 |
| 30 + | 3 |
| **Marital status:** | |
| Single | 4 |
| Married | 7 |
| Separated or divorced | 4 |
| **Occupation:** | |
| Blue collar | 4 |
| White collar | 4 |
| Professional | 3 |
| Houseworker | 1 |
| Student | 3 |
| **Education:** | |
| High school not completed | 4 |
| High school completed | 2 |
| 1-2 years college | 3 |
| College completed | 5 |
| Advanced degree | 1 |
| **Presenting complaints:** | |
| Marital problems | 5 |
| Depression | 3 |
| Anxiety | 3 |
| Social isolation | 4 |
| Drug or alcohol abuse | 4 |
| Suicide attempt | 2 |

The incest histories were remarkably similar (see table 2). The majority of the victims were oldest or only daughters and were between the ages of six and nine when they were first approached sexually by their fathers or male guardians (nine fathers, three stepfathers, a grandfather, a brother-in-law, and an uncle). The youngest girl was four years old; the oldest fourteen. The sexual contact usually took place repeatedly. In most cases the incestuous relationship lasted three years or more. Physical force was not used, and intercourse was rarely attempted with girls who had not reached puberty; the sexual contact was limited to masturbation and fondling. In three cases, the relationship was terminated when the father attempted intercourse.

## TABLE 2

### Characteristics of the Incest History

| Characteristic | Incidence |
|---|---|
| **Daughter's place in sibship:** | |
| Oldest daughter | 9 |
| Only daughter | 3 |
| Middle or youngest daughter | 1 |
| Unknown | 2 |
| **Daughter's age at onset of incestuous relationship (years):** | |
| 4 | 1 |
| 5 | 0 |
| 6 | 2 |
| 7 | 3 |
| 8 | 4 |
| 9 | 2 |
| 10 | 0 |
| 11 | 1 |
| 12 | 0 |
| 13 | 0 |
| 14 | 1 |
| Unknown | 1 |
| **Duration of incestuous relationship (years):** | |
| Single incident | 1 |
| 1-2 | 1 |
| 3-4 | 3 |
| 5-6 | [illegible] |
| 7-10 | [illegible] |
| Unknown | 3 |

**Lenore:** *I had already started to develop breasts at age nine and had my period when I was eleven. All this time he's still calling me into bed for "little chats" with him. I basically trusted him although I felt funny about it. Then one time I was twelve or thirteen, he called me into bed and started undressing me. He gave this rationale about preparing me to be with boys. He kept saying I was safe as long as I didn't let them take my pants down. Meantime he was doing the same thing. I split. I knew what he was trying to do, and that it was wrong. That was the end of the overt sexual stuff. Not long after that he found an excuse to beat me.*

In all but two of these fifteen cases the sexual relationship between father and daughter remained a secret, and there was no intervention in the family by the courts or child-protection authorities. Previous studies are based on court referrals and therefore give the erroneous impression that incest occurs predominantly in families at the lower end of the socioeconomic scale. This was not the case in the families of our victims. Of these, four fathers were blue-collar workers, two were white-collar workers, six were professionals, and the occupations of three were not known. The fathers' occupations cut across class lines. Several held jobs that required considerable personal competence and commanded social respect:

college administrator, policeman, army officer, engineer. Others were skilled workers, foremen, or managers in factories or offices. All the mothers were houseworkers. Five of the fifteen families could certainly be considered disorganized, with histories of poverty, unemployment, frequent moves, alcoholism, violence, abandonment and foster care. Not surprisingly, the women who came from these families were those who complained of the most severe distress. The majority of the families, however, were apparently intact and maintained a facade of respectability.

### The Incestuous Family Constellation

Both the apparently intact and the disorganized families shared certain common features in the pattern of family relationships. The most striking was the almost uniform estrangement of the mother and daughter, an estrangement that preceded the occurrence of overt incest. Over half the mothers were partially incapacitated by physical or mental illness or alcoholism and either assumed an invalid role within the home or were periodically absent because of hospitalization. Their oldest daughters were often obliged to take over the household duties. Anne-Marie remembered being hidden from the truant officer by her mother so that she could stay home and take care of the younger children. Her mother had tuberculosis. Claire's mother, who was not ill, went to work to support the family because her father, a severe alcoholic, brought home no money. In her absence, Claire did the housework and cooking and cared for her older brother.

At best, these mothers were seen by their daughters as helpless, frail, downtrodden victims, who were unable to take care of themselves, much less to protect their children.

> **Anne-Marie:** *She used to say, "give with one hand and you'll get with the other," but she gave with two hands and always went down . . . She was nothing but a floor mat. She sold out herself and her self-respect. She was a love slave to my father.*
>
> **Claire:** *I always felt sorry for her. She spent her life suffering, suffering, suffering.*

Some of the mothers habitually confided in their oldest daughters and unburdened their troubles to them. Theresa felt her mother was "more like a sister." Joan's mother frequently clung to her and told her, "You're the only one who understands me." By contrast, the daughters felt unable to confide in their mothers. In particular, the daughters felt unable to go to their mothers for support or protection once their fathers had begun to make sexual advances to them. Some feared that their mothers would take action to expel the father from the house, but more commonly these daughters expected that their mothers would do nothing; in many cases the mothers tolerated a great deal of abuse themselves, and the daughters had learned not to expect any protection. Five of the women said they suspected that their mothers knew about the incest and tacitly condoned it. Two made attempts to bring up the subject but were put off by their mothers' denial or indifference.

Only two of the fifteen women actually told their mothers. Both had reason to regret it. Paula's mother reacted by committing her to an institution: "She was afraid I would become a lesbian or a prostitute." Sandra's mother initially took her husband to court. When she realized that a conviction would lead to his imprisonment, she reversed her testimony and publicly called her twelve-year-old daughter a "notorious liar and slut."

The message that these mothers transmitted over and over to their daughters was: your father first, you second. It is dangerous to fight back, for if I lose him I lose everything. For my own survival I must leave you to your own devices. I cannot defend you, and if necessary I will sacrifice you to your father.

At worst, the mother-daughter relations were marked by frank and open hostility. Some of the daughters stated they could remember no tenderness or caring in the relationship.

> **Martha:** *She's always picking on me. She's so cold.*
>
> **Paula:** *I really don't like my mom. I guess I am bitter. She's very selfish. She did a lousy job of bringing me up.*

The most severe disruption in the mother-daughter relationship occurred in Rita's case. She remembers receiving severe beatings from her mother, and her father intervening to rescue her. Though the physical attacks were infrequent, Rita recalls her mother as implacably hostile and critical, and her father as by far the more nurturant parent.

Previous studies of incestuous families document the disturbance in the mother-daughter relationship as a constant finding.[24] In a study of eleven girls who were referred by courts to a child guidance center, Kaufman et al. reported that the girls uniformly saw their mothers as cruel, unjust and depriving, while the fathers were seen much more ambivalently: "These girls had long felt abandoned by the mother as a protective adult. This was their basic anxiety . . . Though the original sexual experience with the father was at a genital level, the meaning of the sexual act was pregenital, and seemed to have the purpose of receiving some sort of parental interest." [25]

In contrast, almost all the victims expressed some warm feelings toward their fathers. Many described them in much more favorable terms than their mothers. Some examples:

> **Anne-Marie:** *A handsome devil.*
>
> **Theresa:** *Good with kids. An honest, decent guy.*
>
> **Lenore:** *He was my confidant.*
>
> **Rita:** *My savior.*

Although it may seem odd to have expressed such attitudes toward blatantly authoritarian fathers, there are explanations. These were men whose presentation to the outside world made them liked and often respected members of the community. The daughters responded to their fathers' social status and power and derived satisfaction from being their fathers' favorites. They were "daddy's special girls," and often they were special to no one else. Feelings of pity for the fathers were also common, especially where the fathers had lost social status. The daughters seemed much more willing to forgive their fathers' failings and weaknesses than to forgive their mothers, or themselves.

> **Sandra:** *He was a sweet, decent man. My mother ruined him. I saw him lying in his bed in the hospital, and I kept thinking why don't they let him die. When he finally did, everyone cried at the funeral but me. I was glad he was dead. He had a miserable life. He had nothing. No one cared, not even me. I didn't help him much.*

The daughters not only felt themselves abandoned by their mothers, but seemed to perceive their fathers as likewise deserted, and they felt the same pity for their fathers as they felt for themselves.

The victims rarely expressed anger toward their fathers, even about the incestuous act itself. Two of the three women who did express anger were women who had been repeatedly beaten as well as sexually abused by their fathers. Not surprisingly, they were angrier about the beatings than about the sexual act, which they viewed ambivalently. Most women expressed feelings of fear, disgust, and intense shame about the sexual contact and stated that they endured it because they felt they had no other choice. Several of the women stated that they learned to deal with the sexual approach by "tuning out" or pretending that it was not happening. Later, this response generalized to other relationships. Half of the women acknowledged, however, that they had felt some degree of pleasure in the sexual contact, a feeling which only increased their sense of guilt and confusion.

> **Kitty:** *I was in love with my father. He called me his special girlfriend.*
> **Lenore:** *The whole issue is very complicated. I was very attracted to my father, and that just compounded the guilt.*
> **Paula:** *I was scared of him, but basically I liked him.*

Though these women sometimes expressed a sense of disappointment and even contempt for their fathers, they did not feel as keenly the sense of betrayal as they felt toward their mothers. Having abandoned the hope of pleasing their mothers, they seemed relieved to have found some way of pleasing their fathers and gaining their attention.

Susan Brownmiller, in her study of rape as a paradigm of relations between men and women, refers briefly to father-daughter incest. Stressing the coercive aspect of the situation, she calls it "father-rape." [26] To label it thus is to understate the complexity of the relationship. The father's sexual approach is clearly an abuse of power and authority, and the daughter almost always understands it as such. But, unlike rape, it occurs in the context of a caring relationship. The victim feels overwhelmed by her father's superior power and unable to resist him; she may feel disgust, loathing, and shame. But at the same time she often feels that this is the only kind of love she can get, and prefers it to no love at all. The daughter is not raped, but seduced.

In fact, to describe what occurs as a rape is to minimize the harm to the child, for what is involved here is not simply an assault, it is a betrayal. A woman who has been raped can cope with the experience in the same way that she would react to any other intentionally cruel and harmful attack. She is not socially or psychologically dependent upon the rapist. She is free to hate him. But the daughter who has been molested is dependent on her father for protection and care. Her mother is not an ally. She has no recourse. She does not dare express, or even feel, the depths of her anger at being used. She must comply with her father's demands or risk losing the parental love that she needs. She is not an adult. She cannot walk out of the situation (though she may try to run away). She must endure it, and find in it what compensations she can.

Although the victims reported that they felt helpless and powerless against their fathers, the incestuous relationship did give them some semblance of power within the family. Many of the daughters effectively replaced their mothers and became their fathers' surrogate wives. They were also deputy mothers to the younger children and were generally given some authority over them. While they resented being exploited and robbed of the freedom ordinarily granted to dependent children, they did gain some feeling of value and importance from the role they were given. Many girls felt an enormous sense of responsibility for holding the family together. They also knew that, as keepers of the incest secret, they had an extraordinary power which could be used to destroy the family. Their sexual contact with their fathers conferred on them a sense of possessing a dangerous, secret power over the lives of others, power which they derived from no other source. In this situation, keeping up appearances and doing whatever was necessary to maintain the integrity of the family became a necessary, expiating act at the same time that it increased the daughters' sense of isolation and shame.

> **Theresa:** *I was mortified. My father and mother had fights so loud that you could hear them yelling all over the neighborhood. I used to think that my father was really yelling at my mother because she wouldn't give him sex. I felt I had to make it up to him.*

What is most striking to us about this family constellation, in which the daughter replaces the mother in her traditional role, is the underlying assumption about that role shared apparently by all the family members. Customarily, a mother and wife in our society is one who nurtures and takes care of children and husband. If, for whatever reasons, the mother is unable to fulfill her ordinary functions, it is apparently assumed that some other female must be found to do it. The eldest daughter is a frequent choice. The father does not assume the wife's maternal role when she is incapacitated. He feels that his first right is to continue to receive the services which his wife formerly provided, sometimes including sexual services. He feels only secondarily responsible for giving care to his children. This view of the father's prerogative to be served not only is shared by the fathers and daughters in these families, but is often encouraged by social attitudes. Fathers who feel abandoned by their wives are not generally expected or taught to assume primary parenting responsibilities. We should not find it surprising, then, that fathers occasionally turn to their daughters for services (domestic and sexual) that they had formerly expected of their wives.

### The Victims

The fifteen women who reported their incest experiences were all clients in psychotherapy. That is to say, all had admitted to themselves and at least one other person that they were suffering and needed help. Although we do not know whether they speak for the vast majority of victims, some of their complaints are so similar that we believe they represent a pattern common to most women who have endured prolonged sexual abuse in childhood at the hands of parents.

One of the most frequent complaints of the victims entering therapy was a sense of being different, and distant, from ordinary people. The sense of isolation and inability to make contact was expressed in many different ways:

> **Kitty:** *I'm dead inside.*
> **Lenore:** *I have a problem getting close to people. I back off.*
> **Lois:** *I can't communicate with anyone.*

Their therapists described difficulty in forming relationships with them, confirming their assessment of themselves. Therapists frequently made comments like "I don't really know whether I'm in touch with her," or "she's one of the people that's been the hardest for me to figure out." These women complained that most of their relationships were superficial and empty, or else extremely conflictual. They expressed fear that they were unable to love. The sense of an absence of feeling was most marked in sexual relationships, although most women were sexually responsive in the narrow sense of the word: that is, capable of having orgasms.

In some cases, the suppression of feeling was clearly a defense which had been employed in the incestuous relationship in childhood. The distance or isolation of affect seemed originally to be a device set up as protection against the feelings aroused by the molesting father. One woman reported that when she "shut down," did not move or speak, her father would leave her alone. Another remembered that she would tell herself over and over "this isn't really happening" during the sexual episode. Passive resistance and dissociation of feeling seemed to be among the few defenses available in an overwhelming situation. Later, this carried over into relations with others.

The sense of distance and isolation which these women experienced was uniformly painful, and they made repeated, often desperate efforts to overcome it. Frequently, the result was a pattern of many brief unsatisfactory sexual contacts. Those relationships which did become more intense and lasting were fraught with difficulty.

Five of the seven married women complained of marital conflict, either feeling abused by their husbands or indifferent toward them. Those who were single or divorced uniformly complained of problems in their relationships with men. Some expressed negative feelings toward men in general:

> **Stephanie:** *When I ride the bus I look at all the men and think, "All they want to do is molest little girls."*

Most, however, overvalued men and kept searching for a relationship with an idealized protector and sexual teacher who would take care of them and tell them what to do. Half the women had affairs during adolescence with older or married men. In these relationships, the sense of specialness, power, and secrecy of the incestuous relationship was regained. The men were seen as heroes and saviors.

In many cases, these women became intensely involved with men who were cruel, abusive, or neglectful, and tolerated extremes of mistreatment. Anne-Marie remained married for twenty years to a psychotic husband who beat her, terrorized their children, and never supported the family. She felt she could not leave him because he would fall apart without her. "We were his kingdom," she said, "to bully and beat." She eventually sought police protection and separation only after it was clear that her life was in danger. Her masochistic behavior in this relationship was all the more striking, since other areas of her life were relatively intact. She was a warm and generous mother, a valued worker, and an active, respected member of her community. Lois was raped at age nineteen by a stranger whom she married a week later. After this marriage ended in divorce, she began to frequent bars where she would pick up men who beat her repeatedly. She expressed no anger toward these men. Three other women in this group of fifteen were also rape victims. Only one expressed anger toward her attackers; the others felt they "deserved it." Some of the women recognized and commented on their predilection for abusive men. As Sandra put it: "I'm better off with a bum. I can handle that situation."

Why did these women feel they deserved to be beaten, raped, neglected, and used? The answer lies in their image of themselves. It is only through understanding how they perceived themselves that we can make sense of their often highly destructive relations with others. Almost every one of these fifteen women described herself as a "witch," "bitch," or "whore." They saw themselves as socially "branded" or "marked," even when no social exposure of their sexual relations had occurred or was likely to occur. They experienced themselves as powerful and dangerous to men: their self-image had almost a magical quality. Kitty, for instance, called herself a "devil's child," while Sandra compared herself to the twelve-year-old villainess of a popular melodrama, *The Exorcist*, a girl who was possessed by the devil. Some felt they were invested with special seductive prowess and could captivate men simply by looking at them. These daughters seemed almost uniformly to believe that they had seduced their fathers and therefore could seduce any man.

At one level, this sense of malignant power can be understood to have arisen as a defense against the child's feelings of utter helplessness. In addition, however, this self-image had been reinforced by the long-standing conspiratorial relationship with the father, in which the child had been elevated to the mother's position and did indeed have the power to destroy the family by exposing the incestuous secret.

Moreover, most of the victims were aware that they had experienced some pleasure in the incestuous relationship and had joined with their fathers in a shared hatred of their mothers. This led to intense feelings of shame, degradation, and worthlessness. Because they had enjoyed their fathers' attention and their mothers' defeat, these women felt responsible for the incestuous situation. Almost uniformly, they distrusted their own desires and needs and did not feel entitled to care and respect. Any relationship that afforded some kind of pleasure seemed to increase the sense of guilt and shame. These women constantly sought to expiate their guilt and relieve their shame by serving and giving to others and by observing the strictest and most rigorous codes of religion and morality. Any lapse from a rigid code of behavior was felt as confirming evidence of their innate evilness. Some of the women embraced their negative identity with a kind of defiance and pride. As Sandra boasted: "There's *nothing* I haven't done!"

Those women who were mothers themselves seemed to be preoccupied with the fear that they would be bad mothers to their children, as they felt their mothers had been to them. Several sought treatment when they began to be aware of feelings of rage and resentment toward their children, especially their daughters. Any indulgence in pleasure seeking or attention to personal needs reinforced their sense that they were "whores," and unfit mothers. In some, the fear of exposure took the form of a constant worry that the authorities would intervene to take the children away. Other mothers worried that they would not be able to protect their daughters from a repetition of the incest situation. As one victim testified:

> *I could a been the biggest bum. My father called me a "big whore" and my mother believed him. I could a got so disgusted that I could a run around with anyone I saw. I met my husband and told him about my father and my child. He stuck by me and we was married. I got to the church and I'm not so shy like I was. It always come back to me that this thing might get on the front pages and people might know about it. I'm getting over it since the time I joined the church.*

Her husband testified:

> *The wife is nervous and she can't sleep. She gets up yesterday night about two o'clock in the morning and starts fixing the curtains. She works that way till five, then she sleeps like a rock. She's cold to me but she tells me she likes me. She gets cold once in a while and she don't know why herself. She watches me like a hawk with those kids. She don't want me to be loving with them and to be too open about sex. It makes her think of her old man. I got to take it easy with her or she blows up.*[27]

In our opinion, the testimony of these victims, and the observations of their therapists, is convincing evidence that the incest experience was harmful to them and left long-lasting scars. Many victims had severely impaired object relations with both men and women. The overvaluation of men led them into conflictual and often intensely masochistic relationships with men. The victims' devaluation of themselves and their mothers impaired development of supportive friendships with women. Many of the victims also had well-formed negative identities. In adult life they continued to make repeated ineffective attempts to expiate their intense feelings of guilt and shame.

### Therapy for the Incest Victim and Her Family

Very little is known about how to help the incest victim. If the incestuous secret is discovered while the victim is still living with her parents, the most common social intervention is the destruction of the family. This outcome is usually terrifying even to an exploited child, and most victims will cooperate with their fathers in maintaining secrecy rather than see their fathers jailed or risk being sent away from home.

We know of only one treatment program specifically designed for the rehabilitation of the incestuous family.[28] This program, which operates out of the probation department of the Santa Clara County Court in California, involves all members of the incestuous family in both individual and family therapy and benefits from a close working alliance with Daughters United, a self-help support group for victims. The program directors acknowledge that the coercive power of the court is essential for obtaining the cooperation of the fathers. An early therapeutic goal in this program is a confrontation between the daughter and her mother and father, in which they admit to her that she has been the victim of "poor parenting." This is necessary in order to relieve the daughter from her feeling of responsibility for the incest. Mothers appear to be more willing than fathers to admit this to their daughters.

Though this program offers a promising model for the treatment of the discovered incestuous family, it does not touch the problem of undetected incest. The vast majority of incest victims reach adulthood still bearing their secrets. Some will eventually enter psychotherapy. How can the therapist respond appropriately to their needs?

We believe that the male therapist may have great difficulty in validating the victim's experience and responding empathically to her suffering. Consciously or not, the male therapist will tend to identify with the father's position and therefore will tend to deny or excuse his behavior and project blame onto the victim. Here is an example of a male therapist's judgmental perception of an incest victim:

> *This woman had had a great love and respect for her father until puberty when he had made several sexual advances toward her. In analysis she talked at first only of her good feelings toward him because she had blocked out the sexual episodes. When they were finally brought back into consciousness, all the fury returned which she had experienced at the age of thirteen. She felt that her father was an impotent, dirty old man who had taken advantage of her trusting youthful innocence. From some of the details which she related of her relationship to her father,* ***it was obvious that she was not all that innocent.*** *(our emphasis)*[29]

Not surprisingly, the client in this case became furious with her therapist, and therapy was unsuccessful.

If the male therapist identifies with the aggressor in the incest situation, it is also clear that the female therapist tends to identify with the victim and that this may limit her effectiveness. In a round-table discussion of experiences with incest victims, most of the contributing therapists acknowledged having shied away from a full and detailed exploration of the incestuous relationship. In some cases the therapist blatantly avoided the issue. In these cases, no trust was established in the relationship, and the client quickly discontinued therapy. In effect, the therapists had conveyed to these women that their secrets were indeed too terrible to share, thus reinforcing their already intense sense of isolation and shame.

Two possible explanations arise for the female therapist's flight. Traditional psychoanalytic theory might suggest that the therapist's own incestuous wishes and fantasies are too threatening for her to acknowledge. This might seem to be the most obvious reason for such a powerful countertransference phenomenon. The second reason, though less apparent, may be equally powerful: the female therapist confronting the incest victim reexperiences her own fear of her father and recognizes how easily she could have shared the victim's fate. We suspect that many women have been aware of, and frightened by, seductive behavior on the part of their own fathers. For every family in which incest is consummated there are undoubtedly hundreds with essentially similar, if less extreme, psychological dynamics. Thus the incest victim forces the female therapist to confront her own condition and to reexperience not only her infantile desires but also her (often realistic) childhood fears.

If the therapist overcomes this obstacle, and does not avoid addressing the issue with her client, another trap follows. As one therapist put it during the round-table discussion: "I get angry *for* her. How can she *not* be angry with her father?" Getting angry for a client is a notoriously unsuccessful intervention. Since the victim is more likely to feel rage toward the mother who abandoned her to her fate than toward her father, the therapeutic relationship must provide a place where the victim feels she can safely express her hostile feelings. Rage against the mother must be allowed to surface, for it is only when the client feels she can freely express her full range of feelings without driving the therapist away that she loses her sense of being malignantly "marked."

The feminist therapist may have particular difficulty facing the degree of estrangement between mother and daughter that occurs in these families. Committed as she is to building solidarity among women, she is bound to be distressed by the frequent histories of indifference, hostility, and cruelty in the mother-daughter relationship. She may find herself rushing to the defense of the mother, pointing out that the mother, herself, was a victim, and so on. This may be true, but not helpful. Rather than denying the situation or making excuses for anyone, the therapist must face the challenge that the incestuous family presents to all of us: How can we overcome the deep estrangement between mothers and daughters that frequently exists in our society, and how can we better provide for the security of both?

## Beyond Therapy

For both social and psychological reasons, therapy alone seems to be an insufficient response to the situation of the incest victim. Because of its confidential nature, the therapy relationship does not lend itself to a full resolution of the issue of secrecy. The woman who feels herself to be the guardian of a terrible, almost magical secret may find considerable relief from her shame after sharing the secret with another person. However, the shared secrecy then recreates a situation similar to the original incestuous relationship. Instead of the victim alone against the world, there is the special dyad of the victim and her confidant. This, in fact, was a difficult issue for all the participants in our study, since the victims once again were the subject of special interest because of their sexual history.

The women's liberation movement has demonstrated repeatedly to the mental health profession that consciousness raising has often been more beneficial and empowering to women than psychotherapy. In particular, the public revelation of the many and ancient sexual secrets of women (orgasm, rape, abortion) may have contributed far more toward the liberation of women than the attempt to heal individual wounds through a restorative therapeutic relationship.

The same should be true for incest. The victims who feel like prostitutes and witches might feel greatly relieved if they felt less lonely, if their identities as the special guardians of a dreadful secret could be shed. Incest will begin to lose its devastating magic power when women begin to speak out about it publicly and realize how common it is.

We know that most cases do not come to the attention of therapists, and those that do, come years after the fact. Thus, as a social problem incest is clearly not amenable to a purely psychotherapeutic approach. Prevention, rather than treatment, seems to be indicated. On the basis of our study and the testimony of these victims, we favor all measures which strengthen and support the mother's role within the family, for it is clear that these daughters feel prey to their fathers' abuse when their mothers are too ill, weak, or downtrodden to protect them. We favor the strengthening of protective services for women and children, including adequate and dignified financial support for mothers, irrespective of their marital status; free, public, round-the-clock child care, and refuge facilities for women in crisis. We favor the vigorous enforcement (by female officials) of laws prohibiting the sexual abuse of children. Offenders should be isolated and reeducated. We see efforts to reintegrate fathers into the world of children as a positive development, but only on the condition that they learn more appropriate parental behavior. A seductive father is not much of an improvement over an abandoning or distant one.

As both Shulamith Firestone and Florence Rush have pointed out, the liberation of children is inseparable from our own.[30] In particular, as long as daughters are subject to seduction in childhood, no adult woman is free. Like prostitution and rape, we believe father-daughter incest will disappear only when male supremacy is ended.

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# CHAPTER XIV

# Child Prostitution and Child Pornography: Medical, Legal, and Societal Aspects of the Commercial Exploitation of Children

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The average American citizen, when called upon to describe the problems of child abuse and neglect, typically speaks about the battering or starvation of a child by a parent who hates the child or is mentally deranged. There certainly are many child abuse and neglect cases which fall under such descriptions, but there are many more cases in which the parent or adult perpetrator is motivated by sexual or commercial concerns. The use of a child as an adjunct or tool in fulfilling the parent's aberrant personal desires or needs is a form of child abuse distinguishable from the traditional formulation, yet as devastating to the child. For purposes of discussion in this chapter, exploitative abuse and neglect of children will be defined as physical or emotional harm to a child arising from the use of the child in explicit sexual performances, whether for the purposes of prostitution, sexual exhibition, or the production of pornographic materials.

The majority of the public at large are definite in their lack of understanding or compassion for persons who sell their children sexually or for those who commercially exploit children sexually for economic gain. Yet, the sexual use of children, ranging in age from three to sixteen, has become a multimillion dollar industry. We have documented some of this exploitation through a cooperative effort undertaken by the Odyssey Institute, attorney Anthony Simonetti of the National Obscenity Law Center in New York, Professor George E. Stevens of Purdue University, and Robin Lloyd of Los Angeles; also, much of what follows on child prostitution and pornography is based on articles written originally by the Odyssey Institute for inclusion in the Encyclopedia of Human Problems being compiled by Ann Landers.

### Child Prostitution

Child prostitution is defined as the use of , or participation by, children under the age of majority (sometimes stipulated as under sixteen years of age) in sexual acts for reward or financial gain with adults or other minors when no force is present. Prostitution differs from statutory rape and incest in that there is an element of payment, usually in money, but often in drugs, gifts, clothing, food, or other items. Prostitution is an age-old occupation and a lifestyle for some women, men, adolescent and now, sadly, children occasionally as young as three years old. Sometimes, parents who are involved in the sex-for-sale industries sell their daughters who are too young to understand right from wrong. Child prostitution is closely allied with child pornography, incest, drug addiction, child abuse, and generalized family disruption and juvenile delinquency.

How many children are involved? Experts in the field of juvenile delinquency have shown that in the United States there are a minimum of 300,000 active boy prostitutes under the age of sixteen. Approximately 30,000 of these are located in New York City, with at least 2,000 concentrated in the Times Square area.[1] The Los Angeles Police Department has identified 30,000 boys working as prostitutes within that city; approximately 5,000 of these boys are under fourteen years of age, and several hundred are as young as eight. No one has counted the number of girls involved in sex-for-sale, but most authorities agree that there are probably as many girls involved as boys. In other words, there are more than one-half million children in the United States who are actively engaged in prostitution! Some experts estimate that the number of children involved is easily twice that number—1.2 million, and this includes only children under the age of sixteen. The number nearly doubles again if sixteen and seventeen-year-olds are added.[2]

Odyssey Institute has consulted on this problem in Atlanta, Boston, Chicago, Detroit, Houston, Los Angeles, Milwaukee, New Orleans, New York, and San Francisco, to name but a few cities. Child prostitution is a problem that touches cities in all parts of our nation and children in all walks of life. It has occurred in church-affiliated boys homes (Tennessee), independent schools (Massachusetts), and Boy Scout troops (Louisiana). It has reared its ugly head in the Roman Polanski case (California); in the making of a major movie, "Pretty Baby," which is a story about legalized child prostitution at the turn of the century in Storyville, Louisiana; in the recent death of a twelve-year-old prostitute (New York) who fell or was pushed from a window of a "quick-turnover" hotel; and in the Ms. and Mr. Nude Teeny Bopper Contest, held in Naked City (Indiana). There, children are paid $10.00 each, as are their parents, to enter the contest naked. The public, fully dressed, pay $15.00 to go photograph them. An unexpected visit in the summer of 1977 to one of the truckers' stops in Naked City by CBS Television, Chicago, found eleven and fourteen-year-old girls waiting on tables stark naked for 18 hour shifts for salaries of $15.00 a day. These circumstances were found to be violations of the minimum wage law, the child labor law, and the liquor licensing regulations. There were no laws to address the matter of their nakedness. Fortunately, community and official action in the state of Indiana has halted many of these objectionable practices, but much still remains to be done.

An interesting sidelight is that, in Victorian England, a group of concerned women, led by Josephine Butler, organized to raise the age of girls permitted to work in brothels from nine to thirteen. They were successful.[3]

Children engaged in prostitution often are recruited from rural areas or midwestern cities. Many of them turn to prostitution for survival, others as a form of rebellion. Some leave homes of violence and sexual abuse; others are lonely because of distant, neglectful, personally preoccupied families; and still others are overwhelmingly bored and unchallenged. A few are mentally ill but untreated. The longing for adventure and to be rid of parental abuse leads hundred of thousands into the streets, brothels, and bus terminals. Their common needs are affection, attention, and financial survival. These needs make them vulnerable to smooth-talking pimps who woo them with protestations of love and promises of fun and big money. For some, drugs and alcohol are part of the enticement; for others, these habits follow. Most are involved in substance abuse sooner or later. The drug habit insures their captivity in a lifestyle of domination by others

Many child prostitutes travel from city to city. In some cases, this travel is a result of their employment by organized prostitution rings which carry the children's vital statistics on computers in order to efficiently meet customers' demands. Boston, Chicago, and New Orleans have taken steps to eliminate such technologically advanced rings in recent months. Child prostitutes are rotated around the country like circuit riders because the men who desire children also desire variety. These men need the illusion of innocence and virginity. One child I have treated claimed to have sold her maidenhood forty-four times. In other cases, children wander to avoid arrest or territorial disputes with local established prostitutes. Still others follow conventions of professional and business groups.

What happens to these children? The life of a child prostitute is generally far different from what may have been promised to or anticipated by the child victim. In addition to drug and alcohol abuse, there are frequent beatings by pimps, violence from customers, and conditions of slavery. If a girl has a baby, her pimp may take her child from her and send the infant out of state to be cared for by one of his relatives whose name or whereabouts she does not know. If a prostitute tries to leave his stable (the name for his group of girls) he often threatens her with the reality that she may never see the child again. The youngest mother I personally delivered during my medical training was nine years, eight months old. She had been prostituted by her own mother from age three. When she delivered a son, she thanked God that it was not a female who would have to experience a life similar to her own.

There is often physical damage to children as a result of the premature and inappropriate sexual demands of child prostitution. Nature did not intend for children to have sex with adults; its effects can include lacerations of the genitals, venereal diseases, pregnancy, and local infections of the genitals. The research of Dr. Malcolm Coppleson, one of the leading gynecologists in Sydney, Australia, has shown that the vaginal pH of the pre-pubescent girl is not sufficient to neutralize infections that may come with intercourse. Therefore, she is subject not only to vaginitis, but to the early onset of cervical cancer, a condition that can result in the need for a hysterectomy prior to attaining thirty years of age.[4] It is obvious that children were not meant to satisfy the sexual needs of adults; such use of them, like rape, is a crime of power and abuse. When a child's normal physical development has been disrupted by extensive premature sexual activity, a disruption of emotional development usually occurs as well. How can we expect a child to trust an adult world which sexually exploits him or her?

What kind of people use children sexually? They are almost exclusively men. While occasionally there are cases involving mother-daughter sexual abuse, and, even more rarely, mother-son incest, in cases involving child-sex-for-pay, the buyer is almost always male. These men come from all classes and races, though there is a marked Caucasian preponderance. Many are married, even those primarily interested in boys, and a surprising number are middle or upper class. Many are men of prominence and power. Some are jaded and bored; most feel inadequate and unable to relate meaningfully to peer sexual partners. They see sex as something one person does to another, not as a mutually reciprocal relationship. Sexual activity equals a performance, and they relish an inexperienced child as the judge. Pedophiles, or persons who sexually use children, frequently feel disquieted with themselves and punish themselves with degrading sexual acts that the children have to perform. These acts may be sadomasochistic in nature or involve urine and feces. In contemplating child sexual exploitation, we should not equate healthy adult human sexuality and our own experiences with the activities these children must experience. The size discrepancy alone is cause for pain and fear.

Incredibly, in May, 1977, the first meeting of the International Pedophilic Information Exchange was held in Wales. This is a group of persons who believe that sexual conduct between child and adult is perfectly permissible behavior. Their society is working for the rights of adults to so use "consenting" children. Young children do not have the capacity to judge the consequences or give consent in the true sense. However, there are many American sympathizers with this newest rights movement, and indeed, one association, the Rene Guyon Society in California, claims to have 5000 members who have filed an affidavit that they have each deflowered a child under eight (male or female). The motto of this group is: "Sex by eight or it is too late." I ask you: "Too late for what—to mutilate the spirit and body of a young developing life?"

What can be done? First, we must recognize that a sexually permissive society which lacks a humanistic, caring orientation contributes to the defective value system presently being developed in some children. Children need structure; they need to learn that sex is more than just a mechanical function or a means of earning money. Sex is part of a relationship—a special kind of friendship which is not exploitative. Second, children must be given attention and affection in the home. This includes loving, cuddling, warmth, and concern, basic psychological needs devoid of genital sexual overtones. If these warm, touching experiences are missing in the home, the child may seek them elsewhere, thus becoming vulnerable to sexual exploitation by others.

Third, we must develop and provide all children with a thorough sex education in an atmosphere of human caring and commitment. This does not mean simply providing information on reproductive biology and techniques. While basic explanations are important, children also need honest information about human sexuality and how to manage their feelings. Anatomy classes and warnings about masturbation are no substitute for dealing with the very real concerns and frustrations of adolescence. In addition, all sexual information shared with our young must be age appropriate for them, not for sophisticated adults.

Fourth, when a child does get involved in prostitution, authorities should recognize the behavior as a symptom of more serious problems. The juvenile justice system or other strictly legalistic approaches can not alone prevent or stop the problem. We must take a comprehensive look at the child in trouble, including psychological, medical, educational, legal, and intra-family issues.

Fifth, communities must recognize that child prostitution and pedophilia are very serious threats to all children in the community and to the community itself. Community networks must be organized to fully utilize available, appropriate skills and resources in order to return the victimized child to a happy, healthy, and appropriate lifestyle.

Much remains to be done, but at least we have begun by identifying that these problems exist. Now we must create a society where children can enjoy love and affection without being subjected to sexual abuse and exploitation.

### Child Pornography

America's indifferent attitude toward its children manifests itself in many ways, including, unfortunately, a tolerance of the exploitation of children in the production of sexually explicit films and magazines. Child pornography, also known as "kiddie porn" and "chicken porn," is defined as films, photographs, magazines, books, and motion pictures which depict children under a certain age (usually 16) involved in sexually explicit acts, both heterosexual and homosexual. In 1977, there were at least 264 different magazines produced in America each month that depicted sexual acts among children or between children and adults. These magazines were being produced and sold, for prices averaging over $7.00 each, in adult bookstores across the country. This figure does not include the vast number of films or other media materials that are also available. Until recently, it was incorrectly assumed that child pornography was produced primarily in Europe. However, investigations have revealed that much of it is produced in the United States, although some materials are packaged in such a manner as to appear foreign in origin.

In New York's Time Square, one can purchase *"Lollitots"* or *"Moppits,"* magazines depicting girls ages three to fourteen engaged in explicit sexual activities, as well as playing cards that picture naked, spread-eagled children. Also available is a film depicting female children violently deflowered on their communion day at the feet of a "freshly crucified" priest replacing Jesus on the cross. Another film shows an alleged father engaged in urolagnia with his four-year-old daughter. Of sixty-four films previewed, nineteen showed children, and an additional sixteen involved incest.

Film makers and magazine photographers have little difficulty recruiting youngsters. Some simply use their own children or buy the children of others; some rely on runaways. Recent findings of a U.S. House of Representatives subcommittee indicate that more than one million American children run away from home each year, often for good cause, having been victims of intolerable conditions, with physical and sexual abuse present.[5] From this vast army of dispossessed children, exploiters are able to select thousands of participants for their production needs and prostitution rings.

Los Angeles police estimate that adults in that city alone sexually exploited over 30,000 children under seventeen in 1976 and photographed many of them in the act. Five thousand of these children were under twelve.[6] In 1975, Houston police arrested a man after finding a warehouse full of pornography including 15,000 color slides of boys in homosexual acts, over 1,000 magazines and paperback books, and a thousand reels of film. In New York City, Father Bruce Ritter of Covenant House, a group of shelters for runaway children, has reported that the first ten children who entered Covenant House had all been given money to appear in pornographic films. These children, in their early teens, could not return to their homes because of extreme conditions of abuse and neglect, and could not find jobs or take care of themselves in other than illegal ways. There *is* no other way for a child of twelve to support him or herself, and, sadly, too few sheltering alternative environments are provided by our communities.

Many are not runaways, but come from broken homes. They can be induced to pose for $5.00 or a trip to Disneyland, or even a kind word. Sometimes their mothers are themselves the subjects of pornography; often parents or guardians are addicts or alcoholics. Approximately 2.8 million of our nation's children are in the sole custody of substance abusers, and 2.2 million are with parents involved in sex for sale.[7]

The men who support this billion-dollar industry do so because they are seeking justification and rationalization for their deviant behavior. Indeed, one magazine, *"Lust for Children,"* is a primer for the sex molester, teaching him how to go to the park and pick up little girls, what games to play to induce them to cooperate, and what acts to perform that will leave the least evidence for the police should the children report him. Another, entitled *"Schoolgirls,"* instructs a father (in text and photographs) as to those positions for intercourse best used with pre-pubescent girls. Still another shows, in serial photographs, how to affix a lock to one's daughter's labia so that no other man can "get to her." Such sadomasochistic activities are an integral part of the "kiddie porn" market.

Despite the highly secretive nature of the recruitment and sexploitation process, a growing body of information about the children involved indicates that the psychological scarring and emotional distress which occur in the vast majority of these cases lead to other significant long-term problems, including the illicit use of drugs to deaden memories and desensitize present experiences.[8]

Many of these children are victimized in a most brutal fashion. Los Angeles Police Investigator Jackie Howell rejects the commonly stated belief that nude posing is harmless to children. "We have found that the child pornographer is also often the molester. Photography is only a part of it; it is often only a sideline to prostitution, sexual abuse, and drugs." It is important to note that the victimization in the child pornography process goes beyond the child's role as an actor. For example, authorities in Rockingham County, New Hampshire, report that, in 1977, all 27 cases of incest reported in their jurisdiction included child pornography preceding and accompanying the assaults on the children. Many more such cases are beginning to surface with recent reports from Ohio and California.

There also is evidence to show similarity in the psychological scarring between child pornography and incest victims. Their common feelings of betrayal, guilt, worthlessness, and rage often can be expected to promote inwardly, self-destructive behavior, such as isolation, withdrawal, drug or alcohol abuse. Or the child may turn outward in aberrant social behavior, delinquency, promiscuity, prostitution, or violence.

Psychiatrists report that pre-pubescent sexual activity, especially under conditions of exploitation and coercion, is highly destructive to the child's psychological development and social maturation. It predisposes them to join society's deviant populations: drug addicts, prostitutes, criminals, the promiscuous, and pre-adult precocious parents. Venereal disease in children has now reached epidemic figures.

Psychiatry has not yet developed a treatment design for youngsters involved in pornography, any more than it has for child prostitutes or incest victims, all of whom, understandably, show a marked inability to trust adults or to establish the therapeutic rapport which is so necessary for rehabilitation. These children have experienced the consequences when exploitation and abuse masquerade as "love." It is "love" and its closeness, as previously defined in their lives, that they most fear.

There are many parts to the solution of this problem. This menace will not be removed by simple changes in laws or harsh penalties, although these are essential components of a complete strategy. There must be a heightened public awareness in each community that child pornography exists, that it is very big business, that it victimizes children in every community, that it can be stopped, and that it will only be stopped by a commitment to the children of the community manifested in explicit actions:

1. Amend child abuse and neglect statutes to include commercial sexual exploitation and to prescribe harsh criminal penalties for offenders.

2. Amend Civil Codes to provide for licensing of all children used in commercial modeling or performing, with carefully worded proscriptions and substantial sanctions against the use of these children in sexually explicit activities.

3. Extend criminal liability to include promoters and distributors of child pornography, without whose promotion and marketing of the finished product there would be no financial motive for the sexploitation of children in the first place.

4. Develop intervention and treatment programs for victimized children in order to mend their emotional and psychological injuries and to return them to the mainstream of society.

When Odyssey Institute began its campaign against child pornography in January, 1977, there was very little legislation on the federal or state level dealing with the use of children in sexually explicit materials or performances. On the federal level, five laws prohibit the distribution of "obscene" materials. One prohibits any mailing of such material; [9] another prohibits importing obscene materials; [10] a third prohibits the broadcast of obscenity; [11] and two others prohibit the interstate transportation of obscene materials or the use of common carriers to transport such materials.[12] In addition, the Anti-Pandering Act of 1968 [13] authorizes postal patrons to request non-delivery of unsolicited, sexually offensive mail or advertising. No federal statute specifically regulated the distribution of sexual materials to children. Likewise, no federal statute specifically regulated or restricted the production, distribution, or marketing of this material in interstate commerce. Laws pertaining to the dissemination of obscene material to minors have been enacted in 47 states and the District of Columbia. In early 1977, only six states, however, specifically prohibited the *participation* of minors in an obscene performance that could be harmful to them.[14]

State criminal statutes dealing with sex crimes often offer little help. The physical activity involved in sexploitation of minors in pornography may not meet the criteria of the statute, e.g., rape, sodomy, sexual abuse. Or the statutes may be so broadly worded as to discourage courts from attempting to apply them as significant sanctions. Many states have child welfare provisions within their education laws that regulate the employment of children in commercial activities. Unfortunately, these same laws either abdicate control when the child is working for a parent [15] or the sanctions are so limited as to pose no deterrent.[16]

If the lawmakers insist on classifying the materials as obscene (rather than concentrating on the crime perpetrated in their production), there is still room for excellent argument and protective legislation. The Supreme Court has already upheld restrictions against the sale of obscene materials to minors. If states can constitutionally protect the welfare of minors by restricting the materials that can be made available to them, states can also protect minors from having to participate in the production of such materials. The legislation proposed by the Law and Medicine Division of Odyssey Institute is designed to address the entire industry of child pornography, from soliciting of children to marketing of products. Printed materials cannot be isolated or removed from the process involved in developing them. The protections afforded by the First Amendment's provisions regarding free speech are not without limitations. The First Amendment cannot rationally be interpreted to include a right to abuse and exploit young children.

The welfare of American children must become a priority of government, as well as of the professions. Children's needs are different from those of adults whose voices are heard by policymakers and legislators. We are not going to produce mentally healthy and happy children by issuing an executive order that all children must be loved. But we can develop the treatment resources needed to compensate for the deficits and abuse many of them experience. And we can enact and enforce legislation to protect them and give them a fighting chance in this world.

Given the paucity of legislation specifically relating to this activity, there can be little wonder at the relative lack of rigorous law enforcement. The problems of case-finding and evidence- gathering are compounded by confusion about sexploitation as a form of child abuse and the many unresolved issues related to adult obscenity. These problems and the attitudes of many judges discourage or actually thwart the few criminal investigations attempted. In New York City, for example, police, after a year's investigation, seized 1,200 pornographic films and magazines, many showing children. A major wholesaler subsequently was convicted. He could have been sentenced to seven years in prison; instead, he got six months of "weekends" in jail.[17]

In early 1978, Congress passed a significant new federal statute (P.L. 95225), which prohibits the commercial sexual exploitation of minors. Additionally, more than 30 state legislatures have introduced or passed child pornography legislation. Such legislation can achieve maximum success by prohibiting specific sexual acts when performed by minors for the purpose of producing a film or magazine. The production, distribution, sale, and transportation of such materials in interstate or foreign commerce is now specifically forbidden as a federal crime of sexual exploitation of children, as opposed to obscenity which focuses on the reader or viewer. Thus, legislation should explicitly stipulate that the sexual exploitation of children is a form of child abuse; pornography involving children should be explicitly prohibited on the basis that it is contraband material and evidence of such exploitation. There is ample historical precedent for this in the area of child labor law.

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14. Conn. Gen. Stat. Ann. Sect. 53-25; N.C. Gen. Stat. Sect. 14-190.1, et seq.; N.D. Cent. Code Sect. 12.1-27.1-03; S.C. Code Ann. Sect. 16-414.1 et seq.; Tenn. Code Ann. Sect. 39-3013; Tex. Code Ann. Sect. 43.24.
15. Mich. Act 157, Public Acts of 1947 (as amended) Sect. 409.14.
16. N.Y. Educ. Law Sect. 3231 (a), (c).
17. MacPherson, *Children: The Limits of Porn*, Washington Post, Jan. 30, 1977, Sect. C, at 1.

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# CHAPTER XV

# Family and Couple Interactional Patterns In Cases of Father/Daughter Incest

Maddi-Jane Stern, A.C.S.W.
and
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## Introduction

This paper is intended to supply some background information on the sexual assault of children, particularly in regard to father-daughter incest. It will present a preliminary typology of the dynamics of couples' relationships which may be helpful in understanding the etiology of father-daughter incest and in developing treatment and intervention strategies for the ultimate prevention and control of sexual abuse of children by their parents.

The material presented here is derived from research conducted by the Center for Rape Concern (CRC) under a grant from the National Institute of Mental Health (Grant #MH 21304) and the later clinical experience of CRC staff. The Center for Rape Concern is a specialized agency of the Philadelphia Office of Mental Health and Mental Retardation. It was originally known as the Center for Studies in Sexual Deviance and was established by Joseph J. Peters, M.D., in 1955.

In June 1977, CRC incorporated to provide social and psychological services to victims of sexual assault and to sex offenders in Philadelphia, and to improve the medical, social, and criminal justice system handling of sexual assault victims and sex offenders through training, evaluation, research, education, and consultation. The Center provides social and psychiatric services to victims of sexual assault and out-patient group psychotherapy for sex offenders and couples in cases in which at least one of the partners has sexually assaulted a child (usually his own child).

## Background—The Child Victim of Incest

The Children's Division of the American Humane Association estimates that a minimum of 80,000 to 100,000 children are sexually assaulted each year in the U.S. Yet only the tip of that iceberg is visible in the form of reported cases of sexual abuse. At the Center for Rape Concern, there are approximately 250 pediatric (age 12 and under) sexual assault cases reported each year. This represents 23 percent of all reported cases of sexual assault in Philadelphia. Of these 250 cases, approximately one-third are incest cases, predominantly father-daughter incest. The remainder of the cases involve sexual assault by non-family members.

In most reported cases of sexual abuse, there is little or no physical trauma noted by the examining physician. Actual penile-vaginal intercourse does not usually occur. Health care professionals, social workers, law enforcement personnel, and even the child's primary caretakers, therefore, have little concrete physical evidence of sexual abuse.

In the majority of cases of incest, sexual molestation of the child is not a one-time occurrence. The molestation is often begun as part of an affectionate relationship and progresses to genital manipulation, fellatio and/or cunnilingus, anal intercourse, and, in about 10 percent of the Center's cases, vaginal penetration. This gradual evolution of molestation weighs heavily against reporting. The burden for reporting the abuse usually rests on the child. Within our reporting population, children, more than adults or adolescents, exhibit the most ambivalence with regard to reporting sexual assault. This is not surprising. The child is often made a partner in a conspiracy of silence through bribes, threats, and affection.

## Couples' Interactional Patterns in Incest

Three interactional patterns of parents in "incest families" (i.e., families in which father-daughter incest has occurred) are described below. These patterns have been discerned through clinical observations and must, therefore, be considered preliminary. Too frequently, however, the literature on incest has oversimplified the dynamics of father-daughter incest by implying a single stereotyped interactional pattern among family members. The three patterns presented here are intended to provide an expanded understanding of the dynamics of incest and a basis for further study and research in regard to its etiology, prevention, and control.

The first interactional pattern, the dependent-domineering pattern, is the one most commonly seen at the Center for Rape Concern. It is characterized by a marriage between a dependent, inadequate man and a stronger, domineering woman. He looks to her for support and nurturing. She, in turn, will often speak of having not two but three children, and, in fact, she treats her husband as another child. He has little real power in the family, although he may be provoked to violent outbursts. Eventually, as the mother-wife grows tired of her husband's

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dependency and his inability to meet her needs, she withdraws from him emotionally and sexually. He then may turn to a less threatening more accepting female—his daughter. This often occurs when he is under the influence of alcohol.

The second interactional pattern, the possessive-passive pattern, occurs in some strong, patriarchal families. In such families, the father controls everything. His wife and his children are his possessions. Mother tends to be passive and downtrodden and may be partially incapacitated by some physical illness. The father feels that his daughter belongs to him and that this fact gives him license to use her sexually. Often, he rationalizes his molestation of his daughter, stating that his purpose was to "break her in" to sexual relationships and that he "treats her better than other men would."

The third interactional pattern observed at the Center might be termed "incestrogenic." It is the dependent-dependent pattern. Frequently in these families, one or both of the parents have been sexually abused by their parents or other family members as children. Often, the parent/victim marries, if not another victim of sexual abuse, a victim of childhood emotional deprivation. Clinging to each other, these emotionally dependent adults cannot meet each other's needs or those of their children and, instead, look to their children for parenting and love.

The roles within these relationships can be categorized by using Bateson's theory of logical types. The dependent-domineering couple pattern is one in which role behaviors are complementary. That is, one partner's behavior is complemented by that of the other. The domineering female's behavior, for example, may be complemented by her passive, dependent partner. But, during the dependent partner's violent outbursts, due to alcohol abuse or rages at his own impotence within the family, the domineering female usually becomes frightened, inactive and, therefore, complements her partner's now active behavior. This complementary behavior pattern may also be seen in the possessive-passive incest couple.

The dependent-dependent couple exhibits role behavior that is symmetrical. That is, the same type of behavior is exhibited and exchanged between the two partners. Thus, the inadequate dependent behaviors of one partner are matched and often escalated by the same inadequate, dependent behaviors of the other.

A closer look at these three interactional patterns reveals that all involve relationships in which the overriding characteristic is resentment. Each partner resents his/her mate because each needs his/her mate, and each must depend excessively on the other while being unable adequately to meet the other's needs.

### Family Interactional Patterns

The three couples' interactional patterns described above can foster parental or adult-like behavior in the child. In the experience of CRC staff, victims of father-daughter incest usually have been functioning, at least at times, in a more adult or parental role (clinically termed the parental-child role). For example, when the parents have a dependent-dependent relationship and are unable to meet their responsibilities or each other's needs, the daughter may gradually assume many of the duties of the mother, such as preparing family meals, cleaning house, and caring for younger children. She may come to feel responsibility for caring for her father's needs as well. Her relationship to authority figures in the family (her mother and father) becomes more peer-like as generational boundaries become more blurred and amorphous. In such situations, the child may experience increased power and status and is often given increased privileges and duties within the family.

The over-involvement of father and daughter, even in pre-incest situations, can seriously disrupt the entire family unit. Siblings may become angry and resentful over the attention paid their sister and her increasing authority over them. The victim herself usually harbors anger and resentment toward the mother and grows increasingly estranged from her. In families in which incest occurs, the daughter often feels that she has been forced to meet her father's physical, emotional, and sexual needs because of her mother's inadequacy and that her mother has failed to protect her from her father's sexual advances. If the daughter eventually enters therapy, her hostility toward her mother is often the first to be revealed.

### Response of the Child

The child often enjoys some aspects of the incest relationship, and with reason. In the initial stages of the relationship, the physical closeness and touching may feel good. The power that usually accompanies the relationship can be intoxicating. The child is often accorded adult-like status; she has control over a powerful secret; and she is often the recipient of special gifts and privileges.

Although the child may appear adult-like, she is, however, not an adult. The sexual relationship interferes with her efforts towards mastery of herself and her environment She cannot cope with this adult relationship because she is not sufficiently mature to understand, control, or master it. The continuing and often escalating physical and psychological intrusions into the child's external and internal life space and the resulting stress on her coping abilities often results in reporting. For example, one girl, age 6, after many approaches by her father, reported the assault to her mother after the offender had ejaculated in her mouth. The "pee," as she described it, was so frightening that she could no longer cope with the experience. Another young child told her grandmother about her uncle's advances after she first saw him naked with an erection. She feared the weapon-like appearance of her uncle's penis and believed that it would do physical damage to her.

The child who reports is risking loss of family support and affection. In addition, she is often ambivalent about her feelings toward the offender and torn with guilt over her own role in the incestuous relationship. The older the child the more aware she is that incest is forbidden, therefore, the more guilt she is apt to feel about her involvement in the sexual assault. She may wonder, "Was I bad because I 'participated,' because I enjoyed aspects of my father's sexual advances, because I somehow 'caused' the sexual assault by my actions or my behavior?"

The clinical and research experience of the staff of CRC indicates that at least six factors may affect the response of the child to a sexual assault. These are:

☐ The age of the child at the time of the assault (the child's stage of psycho-social development). The closer the child is to puberty the more potentially traumatic the assault can be.
☐ The severity of the assault.
☐ The relationship of the child to the offender. The closer the relationship the more difficulty one can anticipate in adjustment.
☐ The quality of support received from the child's mother.
☐ The response by the child's father.
☐ The quality of the adult heterosexual relationships which the child has observed in the home prior to the assault.

While these factors appear to affect the immediate response of the child, further study of the long range effects of incest (perhaps by a longitudinal study) is necessary to corroborate this clinical observation.

### Immediate Response of the Couple

When the "family secret" of incest is exposed, many couples separate immediately (especially those involved in dependent-dependent and dependent-domineering relationships). Frequently, however, it appears that these separations result from outside pressures and the parents' perception of the "acceptable" course of action. CRC staff have found that the powerful dependency needs of many of these couples cause them to reunite after the pressures of court and protective service involvement have been removed. A family orientation to treatment is, therefore, helpful from the beginning, even when a separation has occurred.

A family orientation is also important in cases in which the couple's ultimate decision is dissolution of the marriage. In these cases, the discovery of the incest relationship may be the precipitating factor, but the couples involved usually have a long history of severe conflicts. Therefore, it is important, if at all possible, to help family members understand the underlying reasons for the separation. This approach affords the victim some protection from the hostility of her mother, who may blame her for the incestuous relationship and the break up of the family, and that of her siblings, who may blame her for "causing" the removal of their father.

### Intervention Techniques

In the experience of the staff of the Center for Rape Concern and particularly that of the senior author, many incestuous families are best treated with a three-pronged approach. The goals of this type of treatment are: 1) to establish parallel-interdependent roles that encourage the growth and independence of each partner; 2) to help the victim accept and deal with her/his ambivalence, anger and guilt feelings; and 3) to restructure the family by establishing generational boundaries, correcting the enmeshed or diffused boundaries between subsystem members of the family and correcting the estranged parental relationships, and treating the siblings' feelings about the "family secret" and their hostility towards the victim and/or the offender.

In formulating a treatment plan for the incestuous family, the first questions raised are usually whether or not the family should remain together as a unit and whether the child victim needs treatment when no visible behavioral disturbances are observed.

In regard to the dissolution of the family, there is no absolute answer. The child must be protected and, in families where the offender is sociopathic or the mother is unwilling or unable to protect her child, removal of a family member is necessary. However, it should be noted that separation of family members often doubly victimizes the child. The daughter may feel that she is being punished for revealing the family secret and that she is responsible for the break up of the family. One young child, when asked what she wanted to have happen within her family, clearly illustrated this by stating, "I love my father very, very much. I love my mother very, very much. So, if anyone leaves, all I'll do is cry."

Determining treatment needs when there is an apparent lack of behavioral disturbance on the part of the child is also a complex problem. Although the Center has treated incestuous families in which the victim bears no immediately visible psychological or physical scars from the assault(s), it is important to remember that the family dynamics are disruptive and potentially explosive. A child cannot maintain the dual role of child and lover to her parent. The imposition of inappropriate sexual activity disrupts the child's process of mastery of appropriate age-level tasks. In particular, the victim is unable to develop constructive relationships with authority figures. For example, one bright, attractive, outgoing 16-year-old reported an incestuous relationship with her step-father that had been ongoing for two years. Only when she began dating and her step-father attempted to re-establish parental control over her by setting curfews did she rebel. She felt that he had no right to exercise authority over her behavior.

CRC staff have also noted a "time bomb" effect in cases of incest. Experience has shown that it is not unusual for victims to develop problems later in life during puberty, adolescence, or adulthood, even though they appeared unscathed at the time the molestation was discovered. It is not uncommon to find that an early childhood sexual assault or incestuous relationship lies at the root of a woman's inability to form a satisfying, stable, social or sexual relationship. Frequently, these victims enter therapy with a long-standing burden of guilt, ambivalence, and anger.

A variety of therapeutic techniques and theories of intervention may be applied to working with incestuous families. Regardless of the approach, however, it is important for the therapist to have a clear knowledge of the legal aspects of the problem, including state laws governing incest, reporting requirements, etc. Liaison with the local district attorney's office and the child protective service unit are crucial. Sometimes, there is so much denial operating within the family that court mandated treatment is the only way to insure participation in therapy.

In structuring treatment, the therapist may choose to work with the family as a whole, with the mother and victim, with the victim alone, etc. It is critical, however, to establish quickly an open, warm, and empathetic relationship with the child. The therapist may accomplish this by entering the child's world through the use of art therapy, play therapy, etc. The child needs to find quick acceptance of his or her feelings.

Family denial and frequent retraction of the incest report is a common issue in beginning therapy. It is important that the therapist avoid affixing blame on any member of the family. Accountability on the part of all family members is one goal of treatment. Accountability, however, should not be confused with culpability or blame-fixing. Denial often can be overcome by valuing the family's dilemma and not forcing choices. The mother, for example, needs to understand that she does not have to choose between her child and her spouse. It is important to help each member of the family be accountable for his or her own role. Often, the first step is to allow each person to speak only for her/himself. We have found that the ability of family members to speak in the "I" framework is usually minimal. Negotiating skills are often absent, and communication is poor. The beginning phases of therapy involve establishing generational boundaries and teaching elementary family negotiating and communication skills.

Individual counseling with the incest victim may occur simultaneously with family therapy. This does not negate the significance of family therapy; instead, it usually confirms that the therapist's emphasis is on the needs and feelings of individuals within the family.

During the next stages of therapy, separation of family roles has occurred and generational boundaries have been delineated. Usually parents still lack the ability to meet each other's needs with parallel roles. It is during this middle phase that we have found couples' groups to be most beneficial.

The couples group at the Center for Rape Concern is comprised of parents in families in which incest has occurred as well as pedophiles and their spouses. Group psychotherapy with a male/female professional team (psychiatrist, psychologist, social worker, etc.) re-affirms the couple unit and offers a supportive environment for re-learning. Operating in an open-ended fashion and utilizing a core group approach where new members are helped by older members, these couples' groups can focus on the day-to-day problems of the couple. Individual counseling of the couples and/or of each partner may supplement this therapy phase. This treatment cannot be considered short-term and often continues for a year or more. While this approach requires a maximum effort of staff time, it has generally produced long-term growth for all family members and new stability for the family unit. The ending of therapy occurs when the family members are individuated, generational boundaries are fixed, negotiation skills are established, and the couple is solidified as a unit able to meet each other's needs in an appropriate manner.

## Conclusion

This paper presents a preliminary typology of the dynamics of parents' relationships in families in which incest has occurred. Through research and clinical observation the authors have found that the couples' relationships can often be characterized as fitting into one of three patterns: dependent-domineering, possessive-passive, or dependent-dependent. As with all typologies, it must be emphasized that these patterns represent ideal types and no one couple may fit the pattern completely.

The appearance of these patterns is neither a necessary nor a sufficient cause of incest. A multitude of factors appears to influence the occurrence of incest including, in addition to faulty couple interactional patterns, enmeshed and estranged relationships among family members and difficulties in personality development of the father, mother, or daughter.

It is the authors' conclusion that an understanding of the dynamics of the parents' relationships is, however, critical to the development of effective intervention strategies and the prevention and control of sexual abuse of children by their parents.

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# CHAPTER XVI

# Adult Sexual Orientation and Attraction to Underage Persons

A. Nicholas Groth, Ph.D., and H. Jean Birnbaum, B.A.

## Introduction

In seeking his civil rights, the homosexually oriented individual is confronted with the accusation that he constitutes a particular risk to the physical and sexual safety of underage persons. Although there have been a number of studies published on the child molester (e.g., Mohr, *et al.*, 1964; Gebhard, *et al.*, 1965; Karpman, 1964), none has directly addressed this issue. In the course of our professional work we have had an opportunity to study men who have sexually assaulted children. Our aim here is to examine some of the psychosocial characteristics of the child offender with particular attention to the relationship between the offender's choice of victim in regard to sex and his adult sexual orientation.

## Method

According to Massachusetts law, anyone convicted of sexual assault may be referred to the Center for the Diagnosis and Treatment of Sexually Dangerous Persons in order to determine whether or not this individual's behavior

> *indicates a general lack of power to control his sexual impulses, as evidenced by repetitive or compulsive behavior and either violence, or aggression by an adult against a victim under the age of sixteen years, and who as a result is likely to attack or otherwise inflict injury on the object of his uncontrolled or uncontrollable desires.* (Mass. Gen. Laws, *Chap. 123A, Sect. 1)*

During the years 1970-1975, 175 subjects were examined who had been convicted of sexual assaults against children. This group constitutes our sample. All these offenders were male, and in every case there was direct physical and sexual contact between offender and victim. We did not see any offenders who had *only* exposed themselves to children.

Our sample was initially subdivided into two groups on the basis of whether the offender's sexual involvement with a child represented a fixation or a regression in his sexual orientation in regard to age preference.

## Classification

"Fixation" is defined as a temporary or permanent arrestment of psychological maturation resulting from unresolved formative issues which persist and underlie the organization of subsequent phases of development. A fixated offender has from adolesence been sexually attracted primarily or exclusively to significantly younger persons. Sexual involvement with peer-age or older persons, where this has occurred, has been situational in nature and has never replaced the primary sexual attraction to and preference for underage persons.

*Clinical Example of a Fixated Offender.*

Scott is a 20-year-old, white, single male of average intelligence, serving a 2-year sentence for indecent assault. He entered a house where he found an 11-year-old boy asleep. He pulled the boy's pajamas off, fellated him, and ordered the boy to perform oral sex on him. When the victim refused, Scott struck him and forced his penis into the boy's mouth. The victim's parents interrupted the assault. Scott has been attracted to young boys throughout his sexual development beginning at age 13 when he became sexually involved with a 6-year-old neighbor. He would kiss and fondle him, and the boy would masturbate Scott. During adolesence Scott "would run around making every kid in sight—anyone younger than I was. I'd talk them into it. I'd masturbate just looking at a kid or fondle them, play with them and kiss them. It was mostly 'hit and run'—no deep attachments. I'd like them to make me climax, and I wanted them to like it too." Beginning at age 17, Scott earned a living as a male prostitute and as a model for pornographic pictures. Although he engaged in sexual relations with adult males and, on a few occasions, with adult females, he found himself attracted only to young, prepubescent boys.

"Regression" is defined as a temporary or permanent appearance of primitive behavior after more mature forms of expression had been attained, regardless of whether the immature behavior was actually manifested earlier in the individual's development. A regressed offender has not exhibited any predominant sexual attraction to significantly younger persons during his sexual development—if any such involvement did occur during adolesence, it was situational or experimental in nature. Instead, this individual's sociosexual

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interests have focused on peer-age or adult persons primarily or exclusively.

*Clinical Example of a Regressed Offender.*

Ted is a 29-year-old, white, divorced man serving a 1-year sentence for indecent assault. He offered a 10-year-old neighbor boy a ride, drove to a wooded area, and forced the boy to fellate him. He then gave the boy a dollar, offered to buy him some pizza, and drove him home. Ted's earliest remembered sexual experience was that of mutual sexual play with his brother and sister around age 5. He began to masturbate at 15 while looking at pictures in magazines such as *Playboy*. He began dating at age 18 and first experienced intercourse at 20. He would engage in intercourse three or four times a month with various girls until, at 25, he met his future wife. They went together for a year before marriage and engaged in premarital sex. Ted's wife had a 4-year-old son from a previous marriage and bore him a daughter a year after their marriage. He states that their marital and sexual adjustment was good for the first year, but that after the birth of their daughter his wife went to work nights, and "that's when it all went downhill. She found somebody at work she liked better. I felt rotten." Within a year Ted's wife separated from him and his first sexual offense occurred.

Of the 175 subjects, 83 were classified as fixated offenders and 92 as regressed offenders. In addition, these two groups were further subdivided into three categories on the basis of the sex of their victims: those who chose female children, those who chose male children, and those who chose both. Descriptive data were collected in regard to the offender, his offense, and his victim through clinical interviews with these subjects together with a study of pertinent case material. These data are summarized in Table I. None of the subjects was psychotic or seriously retarded.

**Table I. Comparison Between Fixated and Regressed Child Molesters**

| | **Fixation** | | | | **Regression** | | | |
|---|---|---|---|---|---|---|---|---|
| | **Female victim** | **Male victim** | **Female and male** | **Sum** | **Female victim** | **Male victim** | **Female and male** | **Sum** |
| Offender | | | | | | | | |
| Total sample ($n$ = 175) | 28 (16%) | 35 (20%) | 20 (11%) | 83 (47%) | 65 (37%) | 15 (9%) | 12 (7%) | 92 (53%) |
| Age of offender | | | | | | | | |
| Mean age | 28 years | 27 years | 29 years | | 33 years | 36 years | 32 years | |
| Range | 17-61 | 15-50 | 17-52 | | 15-56 | 20-64 | 20-48 | |
| Marital status | | | | | | | | |
| Single | 22 (13%) | 33 (19%) | 18 (10%) | 73 (42%) | 16 (9%) | 6 (3%) | 1 (1%) | 23 (13%) |
| Married | 6 (3%) | 2 (1%) | 2 (1%) | 10 (6%) | 49 (28%) | 9 (5%) | 11 (6%) | 69 (39%) |
| Adult sexual orientation | | | | | | | | |
| Heterosexual | Does not apply | | | | 62 (67%) | 5 (5%) | 3 (3%) | 70 (76%) |
| Homosexual | Does not apply | | | | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Bisexual | Does not apply | | | | 3 (3%) | 10 (11%) | 9 (5%) | 22 (24%) |
| Victim | | | | | | | | |
| Age of victim | | | | | | | | |
| Mean age | 8 years | 11 years | 9 years | | 10 years | 11 years | 10 years | |
| Range | 3-15 | 2-16 | 3-15 | | 2-16 | 6-16 | 3-14 | |
| Offense | | | | | | | | |
| Offender-victim relationship | | | | | | | | |
| Stranger | 12 (7%) | 12 (7%) | 10 (6%) | 34 (19%) | 15 (9%) | 6 (3%) | 2 (1%) | 23 (13%) |
| Acquaintance | 7 (4%) | 21 (12%) | 7 (4%) | 35 (20%) | 12 ( 7%) | 4 (2%) | 4 (2%) | 20 (11%) |
| Friend | 6 (3%) | 2 (1%) | 3 (2%) | 11 (6%) | 17 (10%) | 4 (2%) | 4 (2%) | 25 (14%) |
| Relative | 3 (2%) | 0 (0%) | 0 (0%) | 3 (2%) | 21 (12%) | 1 (1%) | 2 (1%) | 24 (14%) |
| Type of act | | | | | | | | |
| Nonpenetration | 16 (9%) | 19 (11%) | 10 (6%) | 45 (26%) | 31 (18%) | 6 (3%) | 3 (2%) | 40 (23%) |
| Penetration | 10 (6%) | 13 (7%) | 8 (5%) | 31 (18%) | 23 (13%) | 6 (3%) | 6 (3%) | 35 (20%) |
| Both | 2 (1%) | 3 (2%) | 2 (1%) | 7 (4%) | 11 (6%) | 3 (2%) | 2 (2%) | 17 (9%) |
| Modus operandi | | | | | | | | |
| Seduction-enticement | 7 (4%) | 11 (6%) | 7 (4%) | 25 (14%) | 20 (11%) | 5 (3%) | 3 (2%) | 28 (16%) |
| Intimidation-threat | 16 (9%) | 13 (7%) | 9 (5%) | 38 (22%) | 31 (18%) | 7 (4%) | 9 (5%) | 47 (27%) |
| Force-attack | 5 (3%) | 11 (6%) | 4 (2%) | 20 (11%) | 12 (7%) | 3 (2%) | 0 (0%) | 15 (9%) |

## Results

A number of observations can be made from these data:

1. The subgroups of fixated and regressed child molesters are approximately equal in size, with the average age for the fixated group (in their late 20s) being slightly younger than that for the regressed group (in their middle 30s). The regressed group would necessarily have to be older since they would need to have achieved a sexual adjustment in adulthood prior to their regression.

2. Although, overall, a majority of offenders (67%) were known to their victims, the majority (83%) of the fixated offenders were either complete strangers or only casually acquainted with their victims, whereas the victims of the regressed offenders were equally distributed among relatives, close friends, casual acquaintances, and complete strangers. This might suggest that the sexual offense is premeditated by the fixated offender, who selects victims who are relative strangers in order to reduce the risk of identification and apprehension, whereas for the regressed offender the offense may be relatively more impulsive and opportunistic.

3. The most predominant method of engaging the victim in the sexual act, by both groups, was through intimidation or threat (49%). Typically, this involved either physically overpowering the victims or threatening to harm them if they resisted. The next most frequent approach was through seduction or enticement (30%), where the victims were bribed, tricked, or pressured into the sexual activity by means of rewards and/or adult authority. A smaller number (20%) of offenses were characterized by a brutal and violent attack on the victims in which the specific aim was to hurt or harm them.

4. The offenders in general appeared to be highly specific in regard to both the sex of the victim chosen and the type of act committed. The majority of offenders, both fixated and regressed, selected either female victims (53%) or male victims (29%) rather than both sexes (18%), and they engaged in sexual acts which either were confined to sexual play (49%) or involved sexual penetration (38%) rather than both (13%). This seems to imply that the sexual attraction to children has particular and specific psychological dynamics underlying it rather than being the result of either situational opportunity or an indiscriminate, unorganized, polymorphous sexual desire.

5. The victims for both groups were predominantly prepubertal children, with a mean age of 10 years. Although the operational definition for "child" is anyone 16 years of age or younger, the large majority of victims for both the fixated group (74%) and the regressed group (69%) were 12 or under. Within this range, male victims appeared to be slightly older on the average for both groups.

6. Female children ($n = 109$) were victims of sexual assault almost twice as often as male children ($n = 66$), but in comparison to the proportion of individuals in the general population who are attracted to persons of the opposite sex, the male child appeared to be overrepresented as a victim. There were more male victims (42%) than female victims (34%) in the fixated offender group, and more female victims (71%) than male victims (16%) in the regressed offender group. What this might suggest is that one of the dynamics underlying pedophilic behavior is an identification with the child. This would account for the overrepresentation of male victims since all the offenders are men.

7. The large majority (88%) of the fixated offenders never married, whereas the large majority (75%) of the regressed group did marry. This is consistent with our definition of the regressed offender as a person who establishes peer-age, sociosexual relationships. About half of the marriages ended in divorce or separation, which is consistent with current national trends. The few (12%) fixated offenders who did marry did so for other than sexual reasons and continued to prefer children sexually.

8. Those offenders who regressed to children from adult sexual relationships were, for the most part (76%), exclusively heterosexual in their life-style. There was a small group (24%) who were classified as bisexual, meaning that in their adult relationships they engaged in sex on occasion with men as well as with women. However, in no case did this attraction to men *exceed* their preference for women, and in every case the sex partners, male and female, were adults. There were no men who were primarily sexually attracted to other adult males found among the group of regressed child offenders.

## Discussion

The child offender is a relatively young adult either who has been sexually attracted to underage persons almost exclusively in his life or who turns to a child as the result of stresses in his adult sexual or marital relationships. Those offenders who are sexually attracted exclusively to children show a slight preference for boys over girls, yet these same individuals are uninterested in adult homosexual relationships. In fact, they frequently express a strong sexual aversion to adult males, reporting that what they find attractive about the immature boy are his feminine features and the absence of secondary sexual characteristics such as body hair and muscles.

Those offenders who established adult sexual relationships and turned to children for sexual gratification only when their adult relationships became stressful are predominantly heterosexually oriented. These child offenders select girls much more often than boys as victims.

In summary, based on a random sample of those convicted child offenders whom the Massachusetts courts deem a substantial risk to the community and adjudicate as dangerous, we find that female children are victimized almost twice as often as male children, and that those offenders who select male child victims either have always done that exclusively in their lives or have done so after regressing from adult sexual relationships with women. There were no peer-oriented homosexual males in our sample who regressed to children. Homosexuality and homosexual pedophilia are not synonymous. In fact, it may be that these two orientations are mutually exclusive, the reason being that the homosexual male is sexually attracted to masculine qualities whereas the heterosexual male is sexually attracted to feminine characteristics, and the sexually immature child's qualities are more feminine than masculine. Although there may be some homosexual men who prefer effeminate male partners, the lack of legal bonds and responsibilities for sexual unions between men may more easily allow these persons to replace such sexual partners when relations become strained rather than regressing under such stress to children. In any case, in over 12 years of clinical experience working with child molesters, we have yet to see any example of a regression from an adult homosexual orientation. The child offender who is also attracted to and engaged in *adult* sexual relationships is heterosexual. It appears, therefore, that the adult heterosexual male constitutes a greater sexual risk to underage children than does the adult homosexual male.

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# CHAPTER XVII

# Sexual Misuse and the Family

Alvin A. Rosenfeld, M.D.

## Psychiatric Theories About Incest

Incest has fascinated man from time immemorial. While the regulations vary from culture to culture, all societies have devised rules to govern sexual and marital relationships within the family or kinship. These have usually included an incest taboo. The exceptions to the taboo have been restricted to two areas: 1) In some societies royalty was permitted incest, either to enhance their symbolic separation from the masses or to guarantee that a dynasty's power and wealth would not be diluted by excessive division, and 2) Certain religious or social experiments, such as the early Mormons in Utah, were said to have been permitted incest as part of a religious reaction against the general society (Schroeder, 1915). In the Judeo-Christian tradition, the bible provides the moral guidelines for behavior. It has strict prohibitions against incest. However, the story of man's creation contains incest as an intrinsic necessity for the perpetuation of the species. Thus, Eve is made of Adam and their children must be sexually involved for the human race to continue. This complication in religious tradition is not usually discussed when biblical incest is considered.

It is in the story of Lot where a case of incest is seen as clearly violating the biblical regulations regarding sex within a family. It is fascinating that the tale of Lot's incestuous union with his daughters contains the family constellation so prevalent where father-daughter incest actually occurs: there is an absent mother (Lot's wife had been turned into a pillar of salt, perhaps a metaphor of her sexual and emotional unavailability), and alcoholism is present, in Lot's case, acute intoxication. Finally, the daughters have come to believe that incest is essential to survival, in this case, for the perpetuation of the human race. Interestingly, Lot is portrayed as the innocent victim of his daughters' duplicity. He succumbed only because he was duped into becoming intoxicated. This theme of innocent adults seduced by highly sexed children is a common one.

Modern psychiatric interest in the dynamics of incest began with Freud's (1954) impression that childhood molestation was etiologic in hysteria. He later came to the realization that the matter was far more complex. In some patients, childhood fantasies could contribute to symptoms that were indistinguishable from those seen in women who had actually been seduced as children. Furthermore, in some cases the child would interpret a universal childhood experience, such as seeing a parent naked, as a seduction (Levin, 1974). For this reason, Freud felt that phenomena more universal than actual molestation had to be involved. He derived his theory of infantile sexuality culminating in the Oedipal period from these observations. In this revised theory, hysteria was caused by the failure to set aside the incestuous fantasies of the Oedipal period of childhood. Just as in the story of Lot, Freud's explanation placed responsibility for the incestuous feelings on the child. The adult's contribution in "seductiveness" was occasionally noted, but the prevalent idea was that hysteria and unresolved incestuous feelings were caused by the child's abnormal psychosexual "constitution" (Abraham, 1907). At this time in history, notions about family dynamics were unknown.

For a long time after Freud's pioneering work, most psychiatric studies were strongly influenced by his findings. While Freud never said this, most writers interpreted him to mean that childhood seduction was rare. Incest taboos and the Oedipal period held a more universal importance in understanding human motivation, unconscious forces, and social structure. Freud's theories spurred considerable research into the origins of the incest taboo. Freud's (1913) own contribution to the field was his highly speculative work, *Totem and Taboo.* In this essay, Freud theorized that rules regarding exogamy derived from the "incest horror" which had its origins in prehistory. At some time a group of sons, jealous of their father's sole possession of all the family's women, slew and ate him. Seized by guilt and contrition, they joined together in the incest taboo to assure there would be no recurrence of the event. (Again it is the children whose unrealistic aspirations must be socialized.)

It would be impossible to discuss all the theories of the taboo. The most modern and impressive psychological theory proposed to compete with Freud's was that of Jung (1916). While Freud focussed on the fear of the Oedipal father in originating the taboo, Jung felt the taboo served as a defense against the potentially terrible, frightening and devouring *mother* of the pre-Oedipal period. Jung felt that the taboo was necessary to force mature children out of the home. In this way, it fostered the formation of relationships outside of the family. This helped tribal stability, promoted psychological separation and individuation of the child, and prevented severe regression and engulfment in the pre-Oedipal mother.

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While Freud continued to maintain that many of his patients had in fact been molested, most psychiatrists began to assume that either the memories were fantasies, or that the child had desired the trauma because of an abnormal psychosexual constitution. Litin, et al., (1956) described the unfortunate effect of this erroneous assumption many years later: it drove people with an actual incestuous experience out of therapy, or worse, into psychosis, by continually denying the reality of their experience.

Ferenczi (1933) was a notable exception to this trend. He wrote that childhood seduction was far more common than conventional wisdom or psychoanalytic theory held it to be. Ferenczi reported that he had to revise his clinical practice to take greater notice of the role of actual sexual molestation in causing psychiatric symptomatology. He felt that such molestation had serious effects on ego development by overwhelming the child's ability to cope and by compromising the child's capacity to interact naturally with others.

During the thirties, forties and early fifties, the bulk of research shifted to court-referred populations. This was in sharp contrast to Freud's investigations which were based on an upper-class private practice population that had little contact with the law. Since the court cases involved children of lower socio-economic classes, many of the findings were family and class, rather than incest, related. An interesting conclusion by Bender and Blau (1937) was that the sexual abuse of a child did not give rise to a severely distorted personality. Rather, many of the children studied were charming and precocious. Since the adult involved in these cases was being prosecuted and faced severe penalties, these authors were surprised to note that these children suffered more from general deprivation than from sexual molestation. In fact, many of them were felt to be active participants or initiators in the relationship for which only the adult was to be punished. For very different reasons, the child was again focussed on as the responsible party. While Bender's work is outstanding, her follow-up could not be thorough by her own account. She noted that grossly dyssocial patterns were not the usual sequel to childhood molestation. However, her study could not look more carefully into the question of whether incest led to more subtle distortions of interpersonal relations.

As noted above, because Bender's data derived from cases involved with legal or social welfare agencies, there was an unfortunate mingling of psychiatric and legal data. This tended to focus attention on the question of who was at "fault." In writing that the children were often actively involved, Bender was trying to introduce a more measured and accurate view of reality. However, the focus on individuals and their traits made it difficult to capture the complexities of these cases.

Beginning in the mid-fifties a new emphasis appeared in the literature on incest. Kaufman, et al., (1954) reported their experience in treating eleven cases of incestuous activity between a parent and a child. They wrote of a complex web of interpersonal relationships involving three generations of a family in complicated *interpersonal* dynamics. Though they reported the individual traits of the family members, their conceptualization was multi-generational and oriented towards the social economy of the family. This focus would merge in the sixties with the growing interest in the family dynamics.

Perhaps the most important work of the fifties was Weinberg's classic research on incest. Weinberg (1955) studied 203 families in which incest had occurred, primarily between a father and a daughter. All of his cases had been reported to the courts and in many one participant had been incarcerated. As a sociologist, Weinberg was particularly concerned with the family structure. He felt that incest could occur in two different types of families. The first was the ingrown or "endogamous" family, where members of the family were not able to form meaningful relationships outside the home. In endogamic families, incest was often seen as being less reprehensible and frightening than adultery since it involved people already familiar with each other. This notion would later be developed by Lustig, et al., (1966). The second type of family was loosely organized with sexual relationships of all types permitted with few restrictions. In these families, incest was just one aspect of a more general promiscuity. Weinberg was less interested in the intrapsychic determinants of incest in his familial conceptualization. However, his findings were readily adapted to the psychiatric literature.

Subsequent to Kaufman and Weinberg reports, most studies of incest drew on their data and incorporated both intrapsychic and familial dynamics. In the early sixties, Cormier (1962) and colleagues conceptualized incest as a *symptom* of severe family dysfunction, rather than as etiologic of a certain disorder or as indicative of a particular personality type. Another excellent example of a paper written with this orientation is one by Lustig et al. (1966). Their express purpose was to combine individual and family dynamics in understanding incest. The families they studied seem to have been of Weinberg's "endogamic" variety. They felt that people in incestuous families have had long and painful experiences with deprivation and separation. As a result, family members are far less concerned with community standards than with intense, pregenital fears of abandonment and with attempts to obtain minimal nurturance. The family's energies were devoted to staying together at all costs. Incest seemed to serve this function. It reduced intra-familial tension. The whole family, including non-participant members, was involved in condoning and supporting the practice. In the presence of the parents' sexual estrangement, all family members were reassured by the incest, reassurance that was vital in the presence of intense separation fears. (These pre-genital fears were the ones that border on the issue of survival first mentioned in reference to Lot's daughters.) Thus, while adultery would threaten the family because one parent was finding sexual satisfaction outside of the family, incest served the structural function of keeping the family together with all needs met internally.

Despite these excellent papers, there was little widespread interest in incest. Because of the assumption that incest was rare, most of the samples derived from court-referred sources. Therefore, the findings found no wider audience. Two factors combined to change this situation. Firstly, when sexual abuse became reportable under child abuse statutes in the late-sixties, protective care agencies were shocked and alarmed by the number of reports they began receiving. The dynamics of these cases seemed to differ from those of physical abuse, yet few guidelines seemed readily available to tell how to approach these situations. Secondly, and for reasons that are unclear, a number of psychiatrists in widely separate geographic areas began to notice that incest was not a rarity in their patient populations. Two examples of this will be mentioned. Lukianowicz (1972) in County Antrim, Ireland, reported that 4 percent of his sample of 700 psychiatric patients had had an incestuous relationship. In our experience with patients in Boston (Rosenfeld,et al., 1977), we found that incest was more prevalent than we had expected. We rapidly identified thirty patients in our clinic with clear-cut incestuous experiences and suspected there were many more. We were fascinated with the fact that each therapist we interviewed was treating several incestuous cases but had assumed he was the only one since incest was thought to be rare. Furthermore, these were not cases of fantasy. Whether these findings represent an increasing openness about all sexual matters or a higher incidence is unclear. The former is more likely. In that vein, it is important to note that these reports do not indicate an "epidemic" of sexual abuse similar to that reported in physical abuse. While the implications of these findings for child development are currently being studied, no definitive answers are as yet forthcoming.

Close examination of the cases being reported revealed that most fell into a broad spectrum of activities from coitus without force to sexual stimulation that had just crossed the border from fantasy. Several of the latter cases involved a father and a post-pubescent daughter long enmeshed in a mutually seductive relationship. On one occasion, often in the context of intoxication, the seduction broke through into action, perhaps fondling or attempted coitus. Only rarely could the case be considered rape. Yet, these cases could show symptomatology as striking and tenacious as cases of long-term coital involvement.

In accordance with Freud's observations, it was our opinion that even in the absence of overt action, these cases might have displayed these symptoms. However, it was our impression that these symptoms often arose in a family atmosphere of seductiveness and provocation rather than simply out of the child's defective "constitution." In these families the seductive nature of parent-child interactions could foster sexualized interpretations of behavior. Moreover, intense Oedipal fantasies and associations in treatment could reflect concerns about the seductive atmosphere of the home, or fear that in that atmosphere one family member might become unable to control sexual impulses (Rosenfeld, 1975). These fantasies might also reflect defective object relations in the family. If the quality of the parent-child interaction is adequate, there is usually a greater sense of safety, a sense absent where incest is threatening to be expressed.

### Sexuality in the Family: A Continuum

The observations we made about the nature of parent-child interactions raised another question. Incest and the sexual misuse of children seemed to be the extreme and very abhorrent ends of a spectrum that included an implicit notion of normality. However, what "normal sexual life" in the family was, remained an unanswered, and often unasked, question. In this context, "sex" and "sexuality" are used in a broad sense to include not only the sexual act, but also those components of childhood affection and tenderness which join the upsurging sexual drive at puberty to form adult sexuality. This term does not refer to gender identity.

Many aspects of appropriate child-rearing are felt to involve elements of sexuality. Glueck and others have noted that some activities associated with nurturance or hygienic care of children can be considered sexual in that they involve "contact with the child's genitalia or produce in the child an emotional response of a sexual nature" (Glueck, 1965:539). These activities include breast-feeding, diapering, and bathing. However, the sexuality implicit in these actions rarely comes into conscious awareness, and is felt to be necessary and healthy.

In the same vein, under optimal circumstances a child has an early life experience with parents who are warm, kind, and tender. The hugging, kissing, and physical closeness seen and experienced at home are also "sexual" in a nurturant and growth-promoting way. The integration of a child into warm and loving aspects of family life is conducive to the child's developing a healthy pride in himself and his parents (Rosenfeld, 1976). In addition, the affection contributes to the child's future ability as an adult to be warm in sexual, marital and parenting relationships. While the hugging, kissing and touching are said to be affectionate but "non-sexual" in motivation when an adult is involved with a child, their sexual and sensual undercurrent becomes quite clear when another adult is the partner.

The child's inclusion in tender aspects of family life must be moderated by other considerations. If being warm and close comes to include behaviors with the child motivated by sexual excitement and curiosity, or is part of a "laissez-faire" attitude that a child should see all aspects of family life, including parental intercourse, the boundaries of "normal" in our society have been overstepped. Some parents try to bring up their child in a way different from their own upbringing, often hoping to rear them free of any sexual inhibitions. In an attempt to undo what they felt was a sexually repressive childhood, these parents disregard the need for privacy and try to be "free" and "open," exposing their children to all aspects of sexual life in the home. Unfortunately, this freedom arises not from genuine comfort but out of the parents' ambivalence. These parents often declare their sexual openness and liberation to hide from themselves and from others their deep uncertainty about adult sexuality. Similarly, while these parents resent their parents' sexual inhibitions, they sometimes also wonder whether they are mistaken in not adhering to the standards they were brought up with. Children can be very aware of this ambivalence. They find it confusing and at the same time stimulating. Often, they do not have sufficient ego strength to deal with their excitement and cannot get help from their parents. This can give rise to numerous symptoms.

On the other hand, the exclusion of a child from all aspects of family sexual life, so that the child is never touched tenderly and never sees the parents embrace or kiss, can probably lead to a form of affective deprivation, perhaps best described as "sexual" neglect.

Providing a good balance so as not to over or understimulate a child, being open in some areas and private in others is a difficult position to achieve. There is a broad range of behavior which would be considered "normal." This spectrum varies both with the cultural background of the family and with the age of the child. Parents generally develop a balance incorporating their personal standards into the ethical mandates of their community. As an example of a cultural difference, Finnish families have traditionally taken saunas together so that nudity in the family is both usual and not sexually provocative. An English family doing the same things with a school age child or adolescent would probably be overstimulating to the child (and to the adults) since nudity is sexual in that culture. What is acceptable behavior among the Trobriand Islanders would horrify the Amish. While none of these cultural standards is necessarily superior to any other, each is adapted to its cultural setting and supports the values of its group.

However, it is not just the specifics of the behavior which determine whether any given action will be overstimulating. All behavior must be understood in the context of the *quality* of the parent-child interaction. Ideally, the parent will provide ego-support to the young child, helping the child to deal with anxiety provoking situations. In the absence of this support, a child may be more easily threatened by behavior which under more supportive conditions would not be overstimulating. Genuine parental comfort which does not come out of unconscious ambivalence and a supportive attitude towards the child are the crucial factors leading to a child's lack of anxiety in sexual matters.

Cultural standards and parental support are not the only factors which determine whether behavior is overstimulating. Behavior must be consistent with the child's stage of development. Actions appropriate at one age may be highly overstimulating at another. Thus, a parent would naturally bathe a one-year-old child and wash its genitalia, but a similar action with a fourteen-year-old, in the absence of extenuating circumstances, such as paralysis, would probably be inappropriate and would evoke anxiety. It would also indicate a serious defect in the parent's judgment. The parents' ability to adapt to the child's changing psychosexual development is vital in facilitating normal development.

### What Are the Acceptable Boundaries?

The important question then is, within a given subculture, what are the acceptable boundaries of family sexual life? Stated otherwise, what is necessary in terms of emotional, affective, sensual and sexual stimulation for a child to grow up in a normal way? Each subculture has devised a culturally acceptable way to rear children which supports those traits it wishes to foster. There are several factors which are aspects of "normal sexual life" in the home:

- ☐ No attempt by the parents to satisfy their adult, genital-sexual needs through their children.
- ☐ No seduction or overstimulation of the child.
- ☐ An ability to tolerate social and personal intimacy between parents and children without actual sexual involvement.
- ☐ A culturally acceptable degree of warmth, affection and stimulation without either discomfort or inhibition in doing what is usual, or disregard for subcultural standards. To provide this, parents must be comfortable with these standards.
- ☐ Adequate privacy for both parents and children in overt sexual matters, but a willingness on the parents' part to transmit honest information about sex to their children. This information should be consistent with the parents' personal and cultural standards.
- ☐ An ability to change and adapt family practices so that they remain suited to the child's changing age and stage of psychosexual development.

In a more general sense:

- ☐ Consistent child-rearing practices and parental agreement on appropriate techniques.
- ☐ Most importantly, a good comfortable relationship between parents and their children.

In this paper, I have traced the evolution of psychiatric ideas about incest. In recent years, incest has been conceptualized as a symptom of family dysfunction rather than as etiologic of certain disorders. In this context, it is important to realize that incest and the sexual misuse of children are extreme ends of a spectrum that includes normal sexual life in the family. Different cultures and families express and incorporate sexuality into the family in varying ways. When sexuality is well-integrated into family life, it supports healthy growth and gives a child a heightened sense of worth and security. Ambivalent expression can lead to overstimulation while complete repression of sexuality in the family can lead to "sexual neglect." In closing, I have proposed some general guidelines of "normal sexual life" in the family.

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# CHAPTER XVIII

# Voices of Victims

This chapter is composed of autobiographical accounts written by adult women and adolescents who, as children, were victims of incest. After so much technical discussion and professional opinion, it seemed only fitting that we include the insights and experiences of a few of the subjects of our concern. Much of their writing is unembellished, raw with emotion, and may make the reader uncomfortable. This is, perhaps, as it should be, since the problem of incest cannot be dealt with effectively from a remote, theoretical vantage point. This material is included with the hope that it will provide helping professionals with a more intimate understanding of the intensity and wide range of emotional, physical, and intellectual reactions that may be experienced by children who have been sexually exploited by family members.

For the most part, these personal statements are accounts of incest between fathers or father figures and daughters. However, we also have included some materials that deal with sibling incest. It has been said that brother and sister incest may be the most prevalent and least traumatic form of incest. There is little doubt that sexual exploration among siblings or cousins, which develops as a result of natural childhood curiosity and experimentation, is fairly commonplace in our society. If the relationships are equal, in terms of age and mental and physical development, they generally are not regarded as sexually abusive and may have no significant consequences. It is another matter, however, when the relationship is an unequal one; e.g., when there is a significant age difference, or when one child exploits the trust or sexual naivete of the other, or when one child is in a position of power or control over another child. Parents often are not aware that one or more of their children is being sexually exploited by a sibling. They may discount the possibility that such a situation could exist and, consequently, they do not recognize (or choose to ignore) its symptoms.

Some victims are too young to ask for help or to understand that they are being used; some are afraid to ask for help; and others have been silenced by years of intimidation. Regardless of the circumstances, once such a situation has been disclosed, steps must be taken to insure that the child is protected from further abuse. The effects of sexual abuse and exploitation committed by a person under the age of eighteen can be as lasting and as damaging to a young child as sexual abuse by an adult perpetrator. The two stories that we have included speak for themselves.

Some authors who contributed to this chapter have used their full names, or they have chosen to use their own or fictitious first names. Others have asked to remain anonymous, and we have honored their requests. The concluding section of this chapter, a letter written to a newspaper by a group of incest victims, offers one of the most telling arguments for our decision to include anonymous material. The young authors of this letter speak for themselves in urging the public media to protect the privacy of the victims of incest.

# Incest: If You Think the Word is Ugly, Take a Look at its Effects

Barbara L. Myers
written with Kee MacFarlane

In the last few years, I have been open about sharing my experiences as an incest victim. I began doing this so that other victims would feel free to come out and share their own experiences and feelings. I also talk about what happened to me so that helping professionals can begin to get a glimpse of what it is like to be sexually abused and can develop a better understanding of some of the damages that may occur as a result of that abuse. I am often asked to describe what my father did to me; the focus of interest or concern or curiosity is usually leveled at the sexual interaction itself, rather than at my feelings about the incest or what I did with those feelings. It is true that I experienced a lot of sexual, physical, and emotional violence at the hands of my father. But the subsequent effects of that abuse and what I did to myself as a result of it had as profound an influence on the course of my growing up as anything he did to me physically.

I believe that children engage in violent or self-destructive behavior for a reason. I believe that when children have pain they are desperately trying to express, they will sometimes do destructive things to themselves and to others in order to be heard. We are all so uncomfortable with destructive behavior that we often cannot see beyond it. We deal with the outward, visible signs of feelings because they are more concrete and easier for us to manage than the pain or fear that may lie beneath them. As a result, it is often a child's behavior that we confront, rather than what a child is really trying to say. I was extremely self-destructive as a child. Sometimes I think there was nothing I didn't try in order to destroy myself. My story is not a pretty one, nor an easy one to write. It is far easier to say what my father did to me than to tell what I did to myself. But I believe that I have come to understand why I did these things, and it is the why that must be told. We must learn to do more than just see the behavior or treat the symptoms of incest. We must learn to hear the pain.

## What He Did To Me

My mother went into the hospital for a nervous breakdown when I was about seven years old. I was supposed to stay with neighbors, but my dad would make me come home to make dinner and visit. All I wanted was my mother. I missed her so much that even the house and the furniture seemed physically different without her. Once in a while my dad would make me stay overnight with him. He'd have me sit by him and would tell me how much he needed me; that was when he began touching me sexually. I didn't really mind it at first. I was so alone and needed the attention and the contact so badly that I wanted him to touch me.

When my mother came back I didn't need or want my dad to touch me anymore, but by that time a pattern had been set that would last until I was 15 and was old enough, or scared enough, or sick enough, or angry enough to cry out for help in a way that was finally heard by some of the adults around me.

In the beginning, I would wake up just as he was leaving my room at night. I wouldn't really know what had just happened. Then I would wake up with his hands on me or just before he came into the room. Later it got so that I would wake up just before his car drove into the driveway. I lived in a constant state of waiting, never knowing when he would be coming into my room. If I could wake myself up before he got to my room, I would often scream as though I was having a nightmare (thinking that he couldn't do anything if I woke up the rest of the family). They would wake up, but he would just wait until they were all asleep again and then come back for me. I also tried sleeping with my sister, but he would carry me out to the couch in the living room and tell the others I'd been sleepwalking if I was still there in the morning.

At first he would just stand by the bed and touch me. Later he began to lay in the bed beside me. Although he began by being gentle, as time went on, his touch became rougher and rougher. He would leave me feeling sore and bruised for days. It was as if he completely lost touch with the fact that I was a child. He was a bully who physically dominated everyone in our family. I saw and heard him beat up my mother so many times that I was in constant fear that he would kill her. I knew that I was no match for him, and I guess I believed that his sexual abuse was somehow better than the physical abuse my mother received.

Total detachment became my way of dealing with what went on at night. I would roll into the wall when he came in, pretending to be asleep, trying to become part of the wall. I would cry hysterically in order to get so far into my own pain that I wouldn't notice what he was doing. With the pillow over my face, I taught myself to totally detach my mind from my body. In pulling myself outside my body, I could actually see myself from the far upper corner of the room; I saw the little girl crying in bed, and I felt sorry for her.

When the intercourse started, it was so physically painful that I couldn't detach from my physical self. I was around 11 years old at the time. It was also the time I began acting out in more overt ways. I began to identify with the physical and emotional pain that was all around me. My tolerance for physical pain increased, and the physical pain that I inflicted on myself acted as a release for the emotional pain that I couldn't express. The rest of this story is about the things I did to myself during and following the years of incest with my father. Mostly, it is about how I felt during that time. It isn't necessarily chronological; instead, I have put it into categories because I have different feelings about each of the things I did. It was as though I knew that I couldn't destroy my father or the things he did to me, but I could destroy myself, thereby destroying the pain and self-hate he caused me.

## *What I Did To Myself*

### Self-Mutilation

When I was young, crying and thumb sucking were my major forms of release. I sucked my thumb to detach and to escape into my own little world. My mother allowed me to do it, but my father hated it. He used to come up behind me and hit me very hard on the back of the head every time he caught me. It was always a tremendous jolt from my world back into his. Mostly, though, I cried a lot. I cried myself to sleep at night, thinking that if I could cry all the feelings out of me maybe it would all go away. I'd cry until my eyes were swollen and my throat sore, and, when I couldn't cry anymore, I used to pinch myself and try to hurt myself in order to keep on crying. That way, I could concentrate on the pain, rather than on what was happening to me. I sprayed perfume and hair spray in my eyes because it stung and kept me crying. I thought that if only I could make myself go blind, my father would be nice to me and my mother might take care of me. The fact that I didn't go blind made me cry even more.

I continued to try to get sick or be physically injured. I told myself that no one would continue to hurt a really sick child. I tried to break my foot by pounding it with a hammer. I jumped off the garage for the same reason. I went out in the rain and soaked my head under the drainpipe trying to get pneumonia. I wanted someone to take care of me, someone to see that I hurt. If they couldn't respond to the real reason, at least they might react to my external pain. But I found that if I got sick and stayed home from school, my father would abuse me during the day. I wanted to go into a hospital so I could get away from my house.

I realize now that my self-destructiveness was also my anger. My crying was an expression of being so afraid and anxious all the time. I was afraid I would turn all of my feelings into anger and end up fighting everyone and everything and be hated. I remember a conscious switch toward anger when I was about 12. I felt such rage that I had to hurt someone. So, I'd hurt myself because I hated myself for being so powerless. I also wanted to be tough—to show others that nothing could hurt me anymore. It gave me a sense of self-worth. My tolerance for physical pain increased, and the physical pain I inflicted on myself acted as a release for the emotional pain I couldn't express. I got several tatoos and prided myself on not feeling the pain. I burned myself from my wrists to my elbows with a cigarette; I still have the scars today. My father said I looked like a zombie, but I didn't care, I *wanted* to be one. I also wanted someone, anyone, to see my pain and acknowledge it. They saw the burns, but I guess they just thought I was crazy, and nothing changed.

### School

I never knew how to act, how to look, or what to wear in school. I had no sense of the appropriate because I always felt that everyone was laughing at me or talking about me behind my back. I felt that they somehow knew about my father, but I was never sure, so I attributed most of these feelings to my looks. I couldn't bring myself to wear makeup or earrings like the rest of the girls (even though I admired theirs). I didn't want to be sexy or look like a woman. If I tried, I just felt uglier. Worst of all, I never really had any peers. They thought I was aloof, whereas I simply didn't know how to relate to them. How could I join in their conversations about boyfriends and first kisses when I was having sex with my father? I never felt like a part of that teenage world because I never was. I could only relate to older boys who were two or three grades ahead of me. The boys talked about sex a lot, and at least that was something to which I could relate. The other girls thought I was a slut because I only hung around with older boys, but none of those relationships were sexual. I never knew how to explain it to them, so I always felt left on the outside.

I always skipped classes that required close contact or focused attention on me. I was good in any subject that didn't require me to perform. I skipped English on the days we were to give a speech or read aloud. I couldn't stand up in front of a class; I was afraid they would see something or, if I opened my mouth, everything about my father would come pouring out. I never asked any questions for the same reason and for fear of sounding stupid. Home economics was another class I avoided because it required both performance and close contact with other girls. I was so afraid I'd fail at whatever project had been assigned and that they would be able to tell something about my secret. Gym class was also a great source of anxiety for me. I wouldn't undress in front of the others; I was afraid they would see something if they saw my body. To me, it was always dirty and ugly and a source of shame. I felt fat, even though I was skinny; I thought I looked different, even though I didn't. I was good at individual sports that didn't require group participation, and I liked them. But I was inept at anything that required involvement with others. Math and spelling were my best subjects, naturally, because I could do them alone. I failed both gym and home economics because, when we weren't doing activities that could be done individually, I didn't go to class. I think of school as an incredibly isolated experience which, like everything else, I survived because I had to.

### Running Away

When I was little and ran away, I always left a note so they would find me (and, I hoped, treat me better when I came back). Later, I hid in a shack clubhouse owned by neighborhood boys. They let me hide there as long as they could be sexual with me. I didn't care. Sometimes, I ran to the home of a girlfriend whose mother was separated from her father. I always hoped her mother would feel sorry for me and adopt me. Every minute I could stay away from home was worth the beating I received when I returned. My father began grounding me for long periods of time so I would be around him more; that was even worse, so I ran away more frequently.

I never thought about where I was running to—only what I was running from. I didn't care where I was going or with whom. I was looking for anyone to take care of me and protect me from my father. I used to think that some man would come along and marry me and take me far away. I also used to steal things, hoping the police would catch me and take me out of my home as an incorrigible child. When I was running, I felt that people showed me the love and caring I hadn't gotten anywhere else. They felt sorry for me, gave me money and food, and made me feel special. I mistook the sympathy of strangers for the caring I wanted so badly. I also learned that strangers aren't always nice. I was raped by some of the men who picked me up. I wanted so much to be taken away by someone that I never even thought about the risks of being physically and sexually abused again. My vulnerability must have been quite obvious in those days. I didn't much care what happened to me, and, as a consequence, a lot of other people didn't either. I was put in my first foster home at the age of fifteen because of my behavior. But by then, running had become my way of dealing with stress.

As I got older, I wasn't afraid for myself when I ran away. I felt that I could take care of myself if no one else would take care of me. What I became afraid of was the thought that I would never be able to stop running. When I was in foster homes, I did stop for a while, but then I always started again. I was afraid I would destroy those other families with my pain. I preferred taking responsibility for not wanting them, rather than risking the possibility of their rejecting me. (In the same way, it always was easier for me to be angry and tell my mother to go to hell than to have to face her inability to protect me from my father.) I was afraid that if I stayed too long in a foster home, others would see how ugly and evil I was inside and wouldn't want me anymore. I was often afraid to start running again, but I was more afraid of staying.

### Drugs

I was 11 years old when I first discovered that drugs could make the terrible world around me disappear. I began sniffing glue to get out of my pain, and it worked. Drugs became my great escape; there was nothing I wouldn't try in order to get high. I never knew how I'd feel after dealing with different people, but, on drugs, I could be anything I wanted to be. I could make up my own reality: I could be pretty, have a good family, a nice father, a strong mother, and be happy. When I was on drugs, I felt high, happy, and in control of my life. When I was high, I had peers; I finally belonged somewhere—in a group with other kids who took drugs. I got a sense of self-worth from being able to handle any kind of drugs. Whatever the others were taking, I took twice as much or more. I wasn't afraid like the rest of them; I got high without worrying about how much I could handle or what it would do to me. It made me feel big and powerful because I didn't care what happened to me.

People said that taking too many drugs would burn out your brains. I used to think that I could become a vegetable if only I could succeed in burning out my brains. I *wanted* to be a vegetable. I used to picture myself as a head of lettuce. I used to look at mentally retarded people and think that they were so happy and didn't care about anything. I envied them because you could spit at them, and they would smile; they didn't seem to understand what hurt was.

Sometimes I am amazed that I didn't succeed in destroying myself with drugs; God knows, I tried hard enough. Half the time, I didn't even know what I was swallowing or care. Later, I purposely used dirty needles in order to get hepatitis. I developed a kind of love/trust relationship with drugs that I had never had with people. I knew they would never fail me the way people had. I could be sure about what the drugs would do to me; I had found a way to feel good and happy—even if it was with drugs instead of people.

### Drinking

For me, drinking had the opposite effect of drugs, which is probably why I did so much of it. Drinking got me back into my pain; it allowed me to express my hurt and my anger (which, of course, I couldn't do on drugs because I couldn't feel any pain). I used to get off on being depressed, on examining how rotten my childhood had been, and how lonely it was to be a kid. I played sad records when I was drunk and let the tears come pouring out.

When I started drinking, I was much too young to buy alcohol so I got older people to buy it for me. They were usually men, and, since they were always interested in sex, I always had something with which to pay. When I drank too much, I got physically sick, but even that was socially acceptable. It wasn't like the times I freaked out on drugs; everyone gets sick from too much booze, so it was all right.

I also got more physically self-destructive when I was drinking. I could tolerate more physical pain when I was drunk: I had been drinking when I burned my arms and during several suicide attempts. I could express my anger under the influence of alcohol, and I purposely started fights so my boyfriends would beat me up. I felt I deserved it. I also remember longing for human closeness, for physical contact of any kind that would prove that others were paying attention to me.

Drinking and drugs put me in touch with different feelings and different people. Drugs made me feel mellow and accepting and gave me passive people from whom it was easy to detach myself both physically and emotionally. Drugs allowed me to be alone in my own world and made me numb to my other painful reality. Drinking, on the other hand, put me in contact with violent, abusive people and helped me drown in my reality. By embracing that violence with my own self-destructiveness, I tried to prove that I could withstand any amount of pain and hurt. Neither of them gave me what I needed, but, in a negative way, they gave me ways of coping with what I had.

### Prostitution

I felt marked. I knew that, wherever I went, men would find me and abuse me. So, my attitude toward prostitution was, "Why not?" If I had to have sex, I thought, why not get something for it? I felt that I deserved the money: other men were going to have to pay for every time my father had me. Nothing they did could repulse me. I had lived with too much of it while I was growing up. After a while, I even made by father give me money and other things I wanted. Even after I left home, I still had that power over him because I carried his secret. I figured that if I couldn't get anything else from him I needed, at least I could get material things.

Since I thought that the only thing men wanted was sex, the only way I could see to get power in a relationship was by making them pay for it. It was my only control, and I could keep it as long as the men didn't mean anything to me; once I cared about them, I felt they had all the control. Prostitution was another way of expressing my rage, of getting back at all of them for what had been done to me. I thought I was ripping them off, rather than the other way around. I saw men as suckers who were going to have to pay for their weakness and desperation. I saw them as needy children. I saw them only in terms of fifty or a hundred dollars. I saw them as anything, except people. I liked to pick up men who didn't speak English; then, I didn't have to listen to them or relate to them in any way, except physically. I had learned to detach my mind from my body at such an early age that it was easy to disassociate myself from those brief, sexual encounters. I thought that other girls were stupid to give it away. I wanted to make a lot of money and get rich so I wouldn't need anyone anymore—not my family, my destructive friends, or men.

Prostitution was a way for me to capitalize on what I thought was the only thing I had to offer. I didn't know how to get pleasure, but I knew how to give it, and, anyway, that was what I was used to. Although I had offers, I would never allow myself to be managed by a pimp. The idea made me furious. No man was ever going to control me like that again. At the same time, I still felt that I wanted somebody to take care of me. I guess taking money from strangers was my distorted way of having them take care of me, even if only financially.

### Suicide

I felt so doomed that I often thought I might as well shorten the agony. I was very young the first time I tried to overdose on a bottle of aspirin. It was scary and difficult to decide whether it was harder to kill myself or to go on living the way I had been. As a result, my suicide attempts were of two kinds: wanting to die and wanting to attempt suicide. With the latter, I was saying, "Help me, or I'm going to die." With the former, I was simply resigned to dying because no one would help me.

I would think about killing myself when all of my other crazy behaviors weren't working and no one seemed to see or care that there was something wrong. I also wanted to die at the times I realized that my various escapes weren't working anymore, and I couldn't keep my feelings and memories pushed out of my consciousness. Mostly, I tried to overdose on drugs, but sometimes I did other things, like cut my wrists. Sometimes, I was relieved to wake up (hoping that others would finally see how bad things had gotten for me); other times, I was bitterly disappointed to find I was still alive.

### Final Thoughts

Well-meaning people often see the behaviors that are associated with pain but fail to hear the pain. Others may actually see the pain but are afraid to deal with it. If they cannot succeed in "curing" the symptoms of childhood pain, they may spend a lot of time diagnosing and labeling those symptoms. Many incest victims bear the various labels of manic depressive, nymphomaniac, frigid, aggressive, schizophrenic, passive, hostile, detached, juvenile delinquent, etc. Thhese labels may help professionals categorize their clients' behavior, but it usually doesn't help them or victims of incest understand why the behavior is happening. Incest victims have been conditioned throughout childhood not to talk about what happens to them. They have been bound to a terrible secret that keeps their feelings locked inside of them. As a result, they may try to express feelings in ways that seem senseless and purely destructive to those who cannot imagine what a childhood of sexual abuse can be like. It doesn't help to tell them to stop feeling sorry for themselves, that they're just trying to get attention, not to be angry, that everybody has pain, or that they must learn to let the past be the past. We must help them share what they are feeling. We must give them encouragement and permission to talk, and listen very carefully when they do. We must give them access to each other so they will realize they are not alone and that it was not their faults.

My anger and my acting out were my survival tactics for many years. These tactics were contained in my self-destructive behavior, and I couldn't stop until I found other ways to survive. It is painful to help people get in touch with the source of their pain. I was lucky to find people who were willing to do that. Thank God someone finally heard what I was saying and what I wasn't saying, so that I could find the words and the tools I needed to get it out of me. I realize now how close it was. I could have died first.

# To My Mother

Barbara L. Myers

I always wanted to be special to you. Dad made you so unhappy. I wanted to make you happy. I even hated him for you. I loved you more than anything.

I remember when you tried to kill yourself. You were lying bleeding in the bathroom and asked Debby to call for an ambulance. I wanted to call. I wanted to help. I cried, not because I was afraid you would die, but because I wanted to take care of you. I felt rejected. I remember when they came and got you, the abrupt men in the white jackets. I wanted to go with you, but you left me. No one would even tell me where you went. I thought you would never return. And you left me with *him*.

All the other kids got to go live with relatives, but I had to stay with the neighbors. I had to go make coffee and sandwiches for Dad. He said he needed me to take care of him because you were gone. I was going to be "Daddy's girl." All the other kids were far away. . . . He was so nice, not the Dad I hated. He wasn't mean to me; he didn't scare me. He said he needed me. Sometimes, he let me stay at our house, instead of next door. That was when he began touching me. It felt funny. I was so alone; I wanted to be close to someone. Mostly, I wanted you to come back. You were gone such a long time. I was scared, and you had left me.

Then, you did come back. It seemed like years later, but I guess it was only months. The other kids came home, too. Dad started being mean and angry again. Only one thing was different; he was nice to me when we were alone, and at night he came into my bedroom.

I *hated* it. He said he loved me, but he didn't. He just wanted me to do what he said. I didn't want him to touch me anymore. I didn't need to be close to him anymore. I wanted to be close to you. I told you I hated him; I asked you to leave him. I was afraid to tell you what he was doing to me. You had enough reason to leave him. I used to sit on the steps, listening to your screams as he beat you, praying he wouldn't kill you. I remember seeing you so many mornings with your black eyes and swollen face. Oh, how I hated him—for you, for me. You said you couldn't leave him until Debby and I got older. You said you needed him because you couldn't take care of five children by yourself. Those were your reasons for putting up with his cruelty, and they became mine. Some nights when Dad was travelling, you would sit on the couch and cry. I hated your pain. I would have done anything to take it away. I bought you presents, cleaned the house; nothing helped.

I began to run away when I couldn't stand it anymore. He would find me, beat me, ground me to the house. Each time, I ran away again. One time after he beat me, you came to my room and held me. You said you loved me more than any of the other kids because I needed you the most. You saw my need for you, but never questioned it. Were you afraid?

It wasn't until I was 15 that I finally told a girlfriend's mother that Dad made me have sex with him. Then, you came over, and I told you. I didn't want to hurt you; I just couldn't take anymore. Debby told you he was doing the same thing to her. You divorced Dad, and we moved into the apartment.

I was still filled with hate, and when you asked the social worker to come to talk with me, I couldn't say a word. The night I took the bottle of aspirin I really wanted to die; it was the only way out. You found me, fed me mustard, and I threw up for two days. Not another word was said about it.

I began using drugs, especially LSD, because they made me forget. I soon became addicted, not caring about anyone or anything. You brought me to court, saying I was uncontrollable. I became a ward of the state. I lived in those foster homes until I was 18; then I was committed to the psychiatric hospital. When I was 19, they kicked me out of the hospital and referred me to Pharm House, a drug treatment center. I went through the drug program, always asking you to come see me. You never came. Then I went through two-and-a-half years of therapy, still asking you to come visit me. You never came. I have reason to hate you. Sometimes, I want to hate you. What stops me from hating you completely? I still want to be your "special" one.

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# To My Father

Barbara L. Myers

I hate! You filled me with this feeling by abusing me sexually, emotionally, physically, and any other way possible. You destroyed me so that you could get your selfish needs met. To you, I had no needs. You took my joy away, the joy I could have experienced in growing up. Everything was centered around *you*. I grew up haunted with fears, haunted with questions:

*Are you going to be home?*
*Are you going to get me?*
*Who are you going to get?*
*Do you love me?*
*Why are you being so nice?*
*What do you want now?*
*How can I get away from you?*
*Will someone find out what you are doing to me?*

Dad, I was a child. I knew something was wrong, but I didn't know what. I trusted you at first. I wanted a father so desperately. I wanted to believe you loved me. I used to say, "This is my father. He must be right." But it was all centered around you, your needs, your sexual needs. I was a child, Dad. Do you know what that is? A little one who is dependent on you to show her the way—not *your* way, *her* way. Oh, how I hate you!

You used to ask me if I loved you. Love you? I was never dumb enough to say no. But I never loved you. You would demand respect. There was no respect. I feared and hated you. I saw your ability to hurt others. I can never forget the times I would cry, thinking you would kill Mom or one of us. I wanted to kill you. Sometimes, I wish I had.

You destroyed my ability to sleep, to think, to develop. My nights were horrors. I used to lie awake in bed and worry whether you were going to come into my room. Sometimes the night fears would overtake me, and I would dream—or perhaps hallucinate—evil things happening. Sometimes, you would take me from my room and tell me I had sleep-walked. You destroyed my trust in my own sanity. I couldn't even develop a conscience. You were nice and gave me gifts for meeting your sexual needs; you punished me when I failed or refused to give you what you wanted. You didn't care about anything else.

Then, there is my body: It was never mine. It was an object for you to sneer at, to touch, to violate, to please *you*. I hated my body. I hated the pain you brought it. I couldn't stand your kisses; they repulsed me—wet slime! I couldn't stand your touch. I used to put a pillow over my face and try to get away in my mind, waiting, waiting for you to be finished. You used to whisper sweet words. You may as well have been saying them to yourself. I never believed you loved me: I always knew your hate.

And when you were done, there I was alone, filled with repulsion at the thought of your touch, your ugliness. I would scream within myself, "I hate him! I hate him!" I tried to cry it all out, cry it away. But even when the tears stopped, I would cry within. I found a thousand ways to hurt myself because of you. You made me addicted to pain.

As for joy, I couldn't cope with that feeling. My pain started with your abuse, and I felt there would never be an end to my pain. I was tied to your life through hate and fear. I could find no way out. I believed there was no way out. I had no self; I had no life. I couldn't get close to anyone. I couldn't trust. I hated everyone, and I hated myself. I felt so alone, unable to speak the truth. I grew to believe I was ugly. I owned *your* ugliness. The only things I could relate to were pain, fear, anger, and abuse.

My rage will never go away!

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# What It Was Like To Be An Incest Victim

Anonymous

I am thirteen years old. I was eleven the first time it happened. My mother was out, but the other kids were upstairs. It was evening. My father had been out drinking. I was in bed. He'd been kind of feeling around before that. He'd pat me when I was in my pajamas and stuff like that. I didn't like it. I felt ashamed. That first time, he came in and started feeling under my pajamas. I was half asleep and didn't know what was happening. He was drunk, and, when he's drunk, he's scary. Before I knew it, he was on top of me, and I kept telling him no, but he said he'd hurt me if I didn't do it. I told him I didn't want to, but he said yes, I'd like it, and he was just showing me how. I didn't like it. It hurt. He was dirty. I don't remember much about it really. I don't want to.

He told me not to tell my mother. But then, he did it again and again. I didn't know what to do. He came in maybe once or twice a week. Sometimes, he'd come right from my mother. I could hear them, and then he'd come in and make me do it. I don't know why I let it go on so long. I feel ashamed. I was so scared, and I was afraid someone would find out. I got really withdrawn and down. My school work was okay, but I didn't make any friends. I just worried all the time.

It was two years before I couldn't stand it any longer, and I told my mother. She told me to tell her if it happened again. I told her it had been going on for a long time, and she got mad. She and my father called me a whore. My mother didn't seem to care. Finally, I just had to do something, and I told my counselor at school. She took me to the police. There was this man there . . . I was supposed to talk to a woman, but she wasn't there, and I had to tell all this to the policeman. I was scared. Later, I had to go to a doctor. He got me on this table and used that cold thing. It was just awful . . . worse than the stuff with my father. I didn't know anything about sex. My mother never told me, and I never had a boyfriend or anything. I still wonder. I worried about getting pregnant; I knew enough to know I could. I still don't know why I didn't. The doctor said I wouldn't.

Now, I live in a foster home. I was glad to get away from both my mother and my father. The worst part of it is that after I did tell about it, it seemed like it was all my fault. Sometimes, I think it was. Why didn't I stop it? I used to get extra things from my father for being so nice to him, but it wasn't worth it. I never care about seeing him again. My mom doesn't want to leave my dad. I don't think she's happy with him, but she's too scared to be on her own. That's one reason I'd *like* to go back home, so I could help her. But I don't know if she really wants me. She didn't seem to care what was happening to me at all. She just blamed me for everything. I think she needs some counseling, too.

I like it in this foster home. They're really nice here. My dad never used to let me go out. I was only supposed to go to school, go home, and work. Now, I get to go out with the other girls at school; we go rollerskating and stuff, and it's fun. But I still flinch if a man touches me. I hate men. Men are dirty; all they want is sex. I'll never marry. I'll adopt children. I like kids.

In fact, that's one of the things that bothers me a lot. I miss my little brothers and sisters, and I know they miss me. I worry about them and feel bad that I'm not home to take care of them. When dad drinks, he gets really mean with them. He hits them with the belt. I want him to get treatment. I don't want him to go to jail. But I don't feel bad about reporting him. I just couldn't stand it anymore. And besides, I'm worried about my sisters. I think he might try something with them, too.

# The Pillar of the Community

***David's View***

My father was very communicative, outgoing. Very effervescent. The pillar of the community type. Lots of friends—more so than my mom.

My father's opinion, for my sister, was very important. My mom's opinion for me was very important. We sort of take after the opposite parent. I take after my mom. I'm very introverted, very studious, college educated, advanced graduate work. My sister attempted college, but that wasn't quite her bag. But she's very mechanical. And my dad was very mechanical.

One of the biggest surprises we had was when he died. And we were driving to the cemetery. We had like a half-mile to a mile funeral procession. The government agency he worked for had sent out like limousines filled with people from where he worked. He knew incredible numbers of people.

That was one of his better sides. He was very outgoing. He was always doing for people in the neighborhood. And my mom was always at home in the backyard. It was a nice blend.

The thing I was jealous in a way of was the kids in the neighborhood. Like my cousins were extremely fond of my dad. He was the idolized dad of the neighborhood. The guy that was out there and could throw a football. And could run. And would repair bicycles. If the neighbors would coast in with their chains off their bikes, there was dad with his tool set putting the chain back on.

I didn't get it because I didn't ride a bike. I was a handicapped kid. I had a congenital leg problem. So I didn't learn to ride a bike until I was like twelve or thirteen.

If the fathers needed help or the kids needed help, they would call and he would be there. But with me he was very cold and distant. At least my recollections are that way—my sister's are different. He was not patient. I don't think he really tolerated me well until later.

What triggered the incest was—I'm the oldest of three children. The middle child died at the age of three, so there is a four year difference between myself and Sara. Well, when the middle child died, two things happened. One was, my mother started back to work as a nurse. And she had to take some extra courses so she'd be out a lot. And the other thing was, we started taking in foster children.

The first young boy we took in was four years older than me, so, in effect, he became my older brother. He was going through puberty and started to ask my dad questions about nocturnal emissions, and things like that. That's where the incest started. It was like my father got him to expose himself, and they went into manipulation. And I walked past it a few times and didn't exactly know what was happening. I would ask questions like, "Why did John have his pants down?" And my dad would say, "Well, I'm just explaining something to him that I will explain to you when you are grown-up!"

So I started to ask the same questions John did. And I went to my dad to ask him. And he started the same sort of thing. You know, "Take down your pants and I will show you how that can happen."

I don't know why he did that. But at first it was fairly normal and natural and I guess we were fairly sheltered. We didn't think anything abnormal about it. When it became abnormal was when he would make John undress and have us manipulate each other. And then he would join in. He would undress and enter into it. Then it got a little worrisome.

Well then, through a series of circumstances, John left our home after about four years, which made him about fifteen years old. Within a few months, we had a younger foster child, a boy, who was five or six—my sister's age. And then my father got into not only me sexually, but he started involving my sister and this other fellow, making them do similar things. I was forced into sexual acts with him. Forced in the sense that he would hold my head in position. He was holding me in position and saying, "Do this. Now do that," and forcibly moving my head.

This was mainly in the evenings. Mother was in night school. And then my dad changed his working hours so he was on day work and would be there when we got home from school but left before she got home.

As far as the early sexual stuff—in a way it was one way I got close to my father because he did not engage in the normal—"Let's go out in the backyard and play catch," or, "Let me show you how to ride a bike or fix a car or do carpentry." He was very impatient with me. I was a klutz. I was uncoordinated in a lot of those areas. So in a way it was a very special—It started out as a very special relationship just between him and me.

But when it got into the physical force aspect of it, I got very resentful and felt very abused. Sort of mutilated, if you know what I mean. That sort of feeling began when I was nine, tenish. I began to feel different. Like I knew my friends' parents weren't doing the same things to them. I mean I didn't ever mention it. It wasn't something to just drop casually into the conversation in the play yard. But I would just feel kind of bad about it.

Pretty soon after that second boy left, the one my sister's age, we got a third foster child, whose name was Mary—who

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was my age. I was then about twelve or thirteen. And about that time, my father was very anxious that I should experience intercourse. I had started to sexually mature. So he was putting Mary and me in very compromising situations and using her as a live demonstration. He was manipulating her and saying, "Now if you really want to turn a girl on, you do this and you do this." It was like sex ed with live demonstrations. And then finally it reached a point that he kept wanting us to have intercourse. And I was quite worried about the possibility of pregnancy, which sounds strange.

At one point, he forced us into a room and locked us in and told us we couldn't come out of the room until we had had sex. And we sort of lay there and looked at each other. He came in and he forcibly took off her clothes. And we still didn't do anything. So he threatened us with bodily harm. He came in with his belt off and sort of wild-eyed and said, "If you don't get it on in a set period of time, I'm going to beat you." What happened at that point was that my mother came into the house and so everything cooled down.

But later he began having sexual relations with Mary, who was sexually active. I mean I learned she had gone through similar circumstances in other foster homes. So had John, the first boy. That was how he gained his keep at the home he was in before ours. And Mary too. It was for special favors. Sort of earning her keep and for special favors.

And sometimes I hated it. But sometimes—there was a different side of my dad that I normally didn't see. There was a seductive quality to it. A total relaxation. He was not as gruff. He was not as stern. There would be some caressing from him which, I guess, I can look at it now and say—there were times and there are times. I know myself well enough now to know that there are definitely times when I want to be caressed. And I want to be touched. And I want to be spoken to gently. And I guess even as a kid, the same moments were there. There were times when it was OK to do that because it sort of fulfilled the need I had.

But we couldn't tell my mother because we had been threatened by my dad. He told us that our mother would kill us if she ever found out because it was evil and dirty and because we were taking part in it. She would punish us, not him.

But I'm the one that finally, ultimately, told my mother what was going on. Because I saw that it was hurting my sister very much, that she had almost committed suicide. My mom took it much better than I would have hoped for. She urged my father to get counseling or therapy and did not leave him, did not divorce him, stood by him.

It was one of the times when my mom was out of the house. And my father had gone in to have intercourse with my sister, which he hadn't done before. He had done other things. But he had never attempted full intercourse with her. And she would not let him do that. And he got very angry with her. Called her a slut and so on and so forth. And I heard all this.

I was extremely angry. And the next thing I remember, he slammed off and went to the recreation room downstairs. My sister was just hysterical and beside herself and went into the bathroom and stayed there for a long time. And then came out. She was crying and all, so I went in to her and talked to her and she said she had gone to the medicine cabinet and taken aspirin—a whole bottle. So I went down to my dad and I started screaming at him and hollering at him, "Look what you've done!" And with that he got up and left the house. He just stormed out of the house. So I took it upon myself to keep her on her feet and kept feeding her black coffee. At this point she was ten. I was fourteen.

And it was a couple of days after the stuff with my sister. And I was extremely nervous, very apprehensive. I remember I said to my mother, "I think you had better sit down. I have something to tell you that you're not going to believe. And I don't want to get anybody in trouble. I don't want to get dad in trouble or anything like that. But he's been making Sara and me—fool around." She said, "Well, what do you mean fool around?" I said, "Making us expose ourselves to each other." And she said, "Well, is that all?" I said, "No. He made us feel each other up." "Well, is that all?" she asked. And I said, "No." "Well, how long has this been going on? Has it just started?" I guess she was looking for a tie-in with his drinking, which he'd started to do right around then and which was becoming a little problem. I said, "No. This has been going on for years." She said, "When does this happen?" I described that it had happened when she was out of the house, at class or at our PTA or different times.

"Well, what did he make you do? And why didn't you tell me?" She was really hurt. I repeated that he told us that she'd skin us alive and that he'd said she would kill us and all this. She said, "Do you really think I would have done that?" And I said no. "Well, why didn't you tell me?"

You know, sort of a double bind. But after I told her, she was very protective. And she lashed into him. She grew quite hysterical. Started yelling and screaming at him, and he sat down and cried. And said he was really sorry. And that he knew it was wrong. And he couldn't help himself. But he also threatened me at that point, too. He said that if he ever got ahold of me alone, he was going to kill me.

And I believed him.

I became sort of sexually inactive for all of junior high school. I didn't date or do anything sexually. And in high school the same way. My only date for all of high school was my senior prom. And I stayed out till all of twelve o'clock. I became very sexually inactive and not interested in either male or female.

I can remember the first time I tried to make it with a girl. I froze. Because the image of the locked bedroom came back. It was like, "You better perform or else." And that was scary. I'm not sure I could definitely say that isn't why I'm more into the homosexual realm of sexual behavior than the heterosexual at the moment. If I were to be really psychological, I would say it would be a way to be close with my father again.

But I would say there is a good deal of anger that I haven't resolved. The question of "Why me?" Was it something my mother was doing? Why did my dad turn to the kids? Why me, as a male child? Even though there is a side to me that says I wish it were totally me, and that he'd left my sister alone. But there is a wondering, a questioning. Was there something in me that triggered something in him? Was it something I did or said. Or should I not have asked my father about sex. Should I have been able to pick up on cues that said he was not capable of answering questions of a sexual nature? Should I have asked my mother, my uncle, my grandfather, you know, anybody else?

Obviously, I wish it had not happened. But I can also see some benefits from it, which sounds very strange. It opened up a counseling side of me—a very sympathetic side. Able to handle people that have troubles in their background.

It was very painful. It made me feel like a complete isolate—dealing with a handicap and dealing with this going on. I look back now and I don't understand how all those years I operated on two different levels. It was very warm and close—and yet I was holding that secret. I look at it now and I don't understand how I could have led such a dual life. I was operating out of fear. Only how could I operate on those two wavelengths? I don't understand.

It does do damage. It makes people feel isolated. It makes them feel different. It makes them take the blame on themselves.

Kids aren't ready. It pushes them. I mean with my sister, she was very knowledgeable about things she should not have known about at that point. Or even been thinking about. At that age, you want to feel safe and in control and intact. She had been violated.

I really think she took it worst.

### Sara's View

My father didn't really have time for us kids. But he was an idol. I don't know if it's just an idea kids grow up with, but you idolize your father. We put him on a pedestal. Everybody loved and feared my father. Feared because he was a big man. Well, big by a little kid's standards. And when my father whistled for us—when he whistled, you hustled.

My mother was a paragon of strength. She was just the epitome of strength. Whenever she said, "Don't," you didn't. Because she's a very stern disciplinarian. But always—the pillar of strength. She sort of guided him as to discipline and how hard. And finally she said no more spankings. And we didn't get spanked. Reprimanded seriously, but not spanked.

The first time I can remember exactly, I was about four years old. We had a foster child at the time. I don't know how old my brother was but my brother was there and the foster boy, who was older than my brother and myself. And my father called me in and he said, "OK, Sara, lie down on the floor." It was the bedroom floor. "Lie down on the floor." Anyway, I did. And that was my introduction to sex. Right there. With the two boys and my father looking down at me.

Four years old. I had no concept of right or wrong. I didn't know it was wrong. It's funny. You know, he had us kids parading around naked and he had us do a few other little goodies. But he was never really a participant. He was on the outside. And he was getting some sex. I had to use two hands. And when he was ready to, you know, well anyway, I was usually called over to finish it off. And I know that at the end of that I got a mouthful of sperm.

And right now, you know, I try to have oral sex with my husband and I just can't. It gags me. And I just sit there the whole time just rigid. And so we just don't do it. I'm sure it all goes back to that. I'm sure if I could get rid of those hang-ups—I mean I'm sure I'm not as experimental as my husband would love me to be. I feel so guilty. I feel like I'm shortchanging him. I'm sure there's other ways to enjoy sex or love-making. I just feel horrible. I just can't do it. I've got all these inhibitions and to a certain extent I'm a prude now.

See, when I was four or so, it didn't bother me. Until my brother told my mother about it. And my mother confronted my father with me present. And then all of a sudden I knew it was nasty. It was a no-no. And then after that point, it repulsed me. Or at least that episode changed my thinking about it.

When he told, I was a little kid still. I'm not sure of the age. I just remember I was four when it all started. But I remember my father and I came back from some place, and my mother was sitting on the couch with my brother. And mom said, "Sara, I want to ask you a question. Herb, don't go away"—that was my father. "Don't leave the room." So I was standing there and mom said, "Has daddy been doing anything to you?" And I knew exactly what she meant. Exactly. And I said yes. So, my mother—she didn't divorce him. She stood by him. She thought that was the end of it. She and I have talked about it since then, and she thought that was the end of it. At that point. Right then. But it wasn't. It continued.

I really don't know why David told. I really don't remember why David told. I know that dad introduced it to all the foster kids we had, too, which is not too cool. But as for how I felt—I hated it as soon as I found out it was a no-no. From the time David told.

I remember specific scenes. I was very young when my father told me that because my brother was born rather sickly my mother took him right to her bosom. When my sister—the one who died—was born, that was the apple of his eye. His daughter, his shining light. Then I came along, and I was just either/or. And when my sister died, it was a whole big chunk of his life that had died. She died at three. I was one. He said that he took me as being his favorite then. And you know—throughout my whole life I felt like a substitute.

It wasn't until I was about twenty-two that I went to a psychologist and I realized that I was not a substitute in every person's life. And that my mother really did love me. You know, a girl always wants to be close to her mother. My mother was good. Don't get me wrong. She really was. She loved me. It just was that I was more of the extrovert, so it seemed like I got in more trouble.

My mother and I talked quite a bit when I was going through all my mental changes, emotional changes, during the period I was going to my psychologist when I felt rejected, depressed. I could never hurt anybody else and I guess that's another part of suppressing anger. I couldn't take my anger out on the people that really hurt me the most. So instead I did bodily harm to myself. I've got scars all over my body. Well, not all over my body, but my arms in particular from burning myself with an iron when I was mad. From just taking a knife when I was angry and slicing my finger or my hand. Because I was mad at somebody else and yet I couldn't do them any damage. I couldn't even yell at them. I had to do it to myself.

And the suicide thing was just that type of thing. A whole mess of things. Everything was just coming down too quickly and I couldn't handle it. It was like—bleed the evil out or something. I must have been a whole lot angrier as a kid than I could ever express. But I'm still not really connected up with that.

When I was going through the therapy bit I expressed a lot of anger I had bottled up inside me from my childhood. And mom felt so guilty. She was horrified. She doesn't cry too often. But she broke down and cried. It was something she didn't know about. And she really felt terrible that it had gone on. She said, "Well, why didn't you tell me?" And I said, "Mom, you're a lovely lady. I love you. But you're just kind of hard to talk to. At that time, anyway, you were." But I was really angry at her for not knowing. For not seeing it. She knew the alcoholism didn't stop. She—never asked about it.

I don't think really she knew the extent of it. She told me she thought it had just started when David blew the whistle. She didn't know it had been going on for years. She had no idea, no way of knowing. And she said she didn't know it continued after that. She figured if anything was going on, we would volunteer the information.

I went through a period of hating my father. Not him so much, because he was a good person. He did work hard. And he was good. I hated what he did. But then I—well, I thought I understood why he did it. Because he had such a bad life as a kid. And he told me one time, too, when he was drunk, that he had slept with his mother.

I don't think he was ever sorry. We never talked about it. You just don't talk about things like that in the family. But I don't think he was ever sorry for it because he figured—in his mind, I'm sure—that it was all right. You know, he was teaching us about sex, and that was his way of teaching us. Now, I'm going to have a little different approach with my kids.

But right until his death I found I was more sympathetic toward dad. I could understand how all this was going on. All these psychology courses and everything in college—I could justify his doing it because of his lousy childhood and because of the death of my sister and how much he felt about it.

And I blamed my mother for cutting out sex. As far as I knew, he wasn't getting any from her. I couldn't swear to that. But that's what he told us. And I guess I believed my father. I would've believed anything he told me. Because he was the only one that really told me that I was loved. You know, my mother would say, "Yes, I love you, Sara. . . ." But he showed me love. As far as sex goes, I'm not saying he showed me love. But you could think of it in terms of that. It was my childish way of thinking he was expressing love for me. He felt more for me than he did for a mistress. He saw me as a mistress, probably.

But now, I feel I'm worth something. I've got kids who need me. I'm living for something. I don't have to feel that I'm a substitute. Because I'm not a substitute, at least for my kids.

I've joined a very conservative church because that way the kids will lead sheltered lives. The people in the church are not street-wise, like I was. They're so immature as far as street knowledge goes. And I was so worldly wise.

I think I condemned my father. I was thinking of having him baptized by proxy, but I decided against that because he did me wrong. He cheated me out of a normal childhood. And I feel I hate him for that. I guess it's why I feel guilt—guilty. Because I hated him. I never loved him.

I really think David took it worst. For some odd reason, I think I'm strongest. This is my personal opinion. I think I'm the stronger person emotionally.

As for why David blew the whistle—I'm sure there are parts of it that I blotted out or have just conveniently forgotten. But I don't remember that at all. I really don't. That's the truth. To this day, it's a real puzzle for me. Why did he blow the whistle? What had dad done to him? I'm sure we both have different memories about the whole experience because I was younger. So some things might stand out differently in my mind.

You know, David and I both have gone different ways, but neither one of us committed suicide. And I have a feeling it's because there were good times, too. And we couldn't exactly hate the man. That's why I think I try to justify a lot of this. Emotions are so hard, so funny to deal with. You can have one strong emotion one way and just keep it that way—like hate. But then something stirs other memories. He could be so good and then so awful. And the pillar of the community. It's kind of funny, isn't it? He was just one mass of contradictions.

# It Hurts to Remember: A Milwaukee Woman's Story

Anonymous

It hurts to remember, even though one never really forgets. I have tried to forgive without success. "Time heals all wounds," they say, but my wounds have only festered through the years. I am a 35-year-old mother of four children. Thirteen years of my child-life were spent in a state of desperate helplessness. When I look at my father today, I feel only pity and sorrow.

I recall that it started when I was five. My mother had a nervous breakdown after my youngest sister was born. I have four sisters, two older and two younger. We were all plagued with sexual abuse by my father, except for my second youngest sister. I cannot understand why or how she escaped. Through the years, I have assumed it was because her godmother was my father's mother. That is just the only conclusion I can come up with.

Primarily, it was oral sex that he had us do at that very young age. It was done innocently by us, without knowledge of wrong-doing. We didn't like doing this for him, but we thought it was a way of life that was not discussed. As time went on, it was the only way he would buy us a doll or shoes, and later, give us our allowance each week.

I feel there was no love for us on my father's part. He was a very selfish person who never really gave a damn for us, or, at least, never showed any consideration for anyone except himself. Friends never felt comfortable coming to the house, neither did relatives. Even salesmen and the paperboy dreaded his rudeness. He would mock our girlfriends by rhyming their names with stupid things.

I recall twice telling my mother that I did not like "doing it for him." The first time was while she was rocking my baby sister to sleep. She told me that I was "talking foolish." I was about six years old then. The second time was when I was about seven or eight. Then, she told me I was hearing things and imagining it.

As a child, I loved my mother, even though she wouldn't accept what we were telling her. She showed us that she cared for us in many motherly ways. I remember when I was older (teenaged) she complained about my father. I suggested she get a divorce, that we would be so much happier. Her response was that we had to protect the family name. I said that if the name was so important, God would have given her a son to carry it on. She hit me!

My mother talked in circles. I never knew what she was saying. When we wanted to talk to her, she never made sense, and we would get very frustrated with her. As I got older, I felt she was living in a make-believe world of her own. Even today, when I talk with her, there are times when I don't understand what she is saying. I feel she does this for attention. When I get upset and tell her to either talk straight or forget talking at all, she will speak to be understood. I must add that she appeared to act childlike when I was growing up. She whispered a lot, and she had a bounce to her walk like that of a little girl. She was employed until I was born, so I doubt she was always so childlike. My reason for giving so much information about my mother is that I feel she was not mentally capable of accepting or handling the incest problem. I do feel that she was aware of it. Her knowledge of it could have driven her into her fantasy world, seeing that this kind of behavior began after her breakdown.

For the most part, the acts of incest occurred in the basement of our house. To this day, I loathe going into that house. Each room is filled with ugly memories. Sometimes, especially while we were quite young, he would insist on oral sex in other places, too. For example, he would pull over on a side street when we were going grocery shopping, or he would promise us a doll or toy and demand sex on the way to the store. I remember when I was about seven, my father ejaculated in my mouth. He leaned back and laughed at me while I spit. I think I have hated to look at him since. That ordeal was the beginning of my rebellion and disrespect.

By the time I was 12, I had begun going to the theater on Friday evenings with a few of my girlfriends. Each Friday, my father would be conveniently located in the basement. If I wanted my allowance, I had to go to him for it. I got smart after a while and said I would be late for the show if I did what he said, and, when I came home, I would refuse him so loudly that he would tell me to go to bed. It was on one of those Fridays that I discovered that what was happening at home with my father was wrong. I made a remark to a girlfriend about hating to go home after the show. As we talked, one thing led to another, and that is how I learned. I remember wanting to run away from home then.

This next part is very confusing for me to record in the order it took place. My oldest sister went into a mental hospital during the period I found out everything from my girlfriend. My sister was 16, and I was 12 or close to it. I had heated arguments with my father. After that one Friday evening, there was never oral sex again, but he never let up on his advances

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**This story was submitted by Adrienne Ahlgren Haeuser, Director of the Region V Child Abuse and Neglect Resource Center. When the author of the story came to the Resource Center to ask if there was a sexual abuse program where she could volunteer, it was suggested that perhaps she could help others most by telling her own story. Identifying information about the author has been changed. What the story does not relate is the fact that the author intimated to her priest, her teachers, and the police what was going on in her home, but no one listened or attempted to intervene.**

toward me. I called him a pig every time he approached me. Sleep was almost impossible. I was afraid to fall asleep because he would sneak upstairs to my room. When I was still awake and heard him coming, I would scream for him to get the hell away from me. Usually, I felt it was safe to try to fall asleep after that. On one occasion, I remember waking up to find him kneeling at the bedside with his hand probing my thighs.

He made my life a hell. He would not let me go out often and was always rude to my dates. He never acknowledged a handshake, and always made a parting remark like, "Don't you two fool around." It was terribly embarrassing and made me feel cheap in the eyes of my date.

He rarely bought me clothes or shoes, and I used to change into a friend's clothes at her house before going to school. Her parents both left for work early and never knew. This friend and one other were the only two who knew what I was going through. To this day, these two girlfriends are my dearest friends always. I feel they helped me pull through the situation without going mad.

I genuinely hated him. I can remember making an actual plan to kill him, just so I could have some peace. I threatened him once with going to the police. He told me he would tell them I was mentally sick like my mother and sister. I felt so helpless. Each day, week, month was terrible. I wanted to die myself. The sounds of passenger trains each night seemed to call me to stand on the tracks.

During this time, my second oldest sister ran away to get married. She was pregnant. My memories of her are somewhat vague, but I recall that her friends were considered wild and that she was usually heavily made up. It was also during this time that I began to suspect that my youngest sister was being abused. She had gotten a new doll for no apparent reason. I talked with her carefully in case my father had threatened her not to tell anyone as he had done with me. After several of these talks, she confided in me.

It was then a battle between my father and me. I felt things could not be much worse for me, so I tried to save my little sister. We argued, and he chased me to my room, got hold of my head, and kept slamming it against the window until the pane broke. Meanwhile, my mother phoned the police from a neighbor's house. Hooray for mother! When the police arrived, I told them everything. My father, as he had threatened, told them I was crazy. I ran to my room crying in fear. Again, I felt helpless because I was sure no one would believe a child over an adult.

After the police left, I controlled my fear enough to go back downstairs. I told my father to leave or I would kill him one night as he slept. I felt it would be worth spending the rest of my life in jail to kill him. He did leave, taking one suitcase. Two days later, he returned, sat down in a chair, and cried for forgiveness. That act didn't last long—about two months. After that, I made a pact with my second youngest sister that we would keep tabs on the whereabouts of our youngest sister at all times.

Throughout the years of this ordeal, I remained a better than average student. When I was at home, I spent as much time as I could in my room doing homework and extra-credit papers. I stayed away from the family with that excuse. School activities and my friends helped me cope with each day. I was also very active in church activities and became youth group president in my senior year. My parents never went to church but always insisted that we go. When I got involved in church activities, my father said it was just an excuse to get out of the house. Perhaps he was partially right. I was lucky. I was with the right group of kids. I shudder to think where I would be today had I gone a different route.

When I became engaged, I insisted that my husband ask for my hand in marriage. He did, and my father told him that he didn't give a damn what we did. Shortly after our engagement, my husband went into the service. On his first leave at Christmastime, I returned to the base with him, and we were married. We have been married for almost 18 years, and the first five were not easy for me. My husband's early hour advances woke me full of terror and the vision of my father. Seeing my husband's penis made me frigid. Having him want me to touch him there angered me and made me wonder if all men were like my father. Intercourse itself never bothered me; it was all the side play that affected me. When we went out for an evening and into a bar (I do not drink), I would feel that I had a special sense to spot men like my father. (My father spent each night after work in a nearby tavern but seldom was uncontrollable when he got home.) As time went on, I felt I was cheating our marriage because of my past. I began to tell my husband about my childhood but was never really specific.

We had three boys at first. I used to think God had blessed me in that way, so I wouldn't associate the past as readily with boys as with girls. My mind was wrapped up with the babies. Eight years after our youngest son was born, we had a daughter. I found myself going back in time once again. I cried many times after my husband fell asleep. We loved her so. How could my father have abused us? How could he have taken advantage of our innocence? Sometimes, when I gave her a bath, I would remember how my father would bathe us and how he would hurt my vagina. When my husband changed her diapers, there were times when such thoughts would flash across my mind. I started having nightmares, waking with screams of, "Get the hell away from her!" Terrible times! Those nightmares ended when I finally told my husband the whole truth about my home life from beginning to end. It shocked him, coming from a beautiful family as he did. But as adults, and knowing a bit more of life and what weird things one can learn from it, we were able to see that it could have been worse and to thank the Lord that it wasn't.

Now, we visit my parents on special occasions or when we are called upon for something. I keep my distance. My children hand my father his presents when there are any for him. There are still times when I want to break down in tears and ask him why. I have felt so many times that I was cheated of a child-life like those of others I have known. I have also felt envious of those with a decent relationship with their parents. My husband's parents died shortly after our first son was born, so there was no one to help fill that desire and need. There are times when I feel hatred and am happy to see my father retired with plenty of time to think about the things he has done. There are times in church when the thought of "honor your father and mother" comes to mind. My husband has many beautiful memories of his father; I wish I had just one to hold onto of my own.

I know I am sounding cruel at this point, but it is how I feel. I could have included many more instances but left them out in the interest of space. I pray that after reading this, you will see the desperate need to prevent or help others from experiencing this kind of upbringing. That is my reason for writing, in part, about my life as a child. I am certain that if centers are established to give aid to incestuous families that the majority of these families could be saved. I also feel that cases of mental illness could be prevented and that there would be declines in incest, divorce, drug use, suicide, and other personal and family tragedies.

# Confronting The Incest Secret

### Meg

When I married, it took me almost two years and an emotional breakdown to tell my husband I had been sexually abused from ages nine to twelve by my father. It took another two years and a second breakdown before I quit refusing psychiatric help. It took two years after that just to build enough trust in my "doctor of the mind" to tell him what I had fearfully told my husband. That's because he was a booming-voiced, big bodied, bearded, pipe-smoking, frightening authority figure to me. It takes me longer to trust what I'm afraid of.

By that time I was 27 years old but still feeling nine years old emotionally. I had uttered THE UNUTTERABLE SECRET to only two people. Why? Because I had never heard human beings say one word about child sexual abuse; I had never seen one brochure or one warning poster about it (like the ones warning us about polio or crime). I hadn't come across anything about it in books or magazines, and it wasn't mentioned on any Marcus Welby-type TV programs or in any films.

Once the doctor knew that I had been abused, he said in later sessions, "Until you talk to your parents directly about this, neither you nor your family will find any peace." That made no sense to me; it was an outrageous idea. My reply each time he guided me toward that end was, "Doctor, I could *never* do that. I'd be too terrified ever to talk about it with them." I felt that, while it might be best for other families to confront the problem openly, *my* family was different.

My father's sexual behavior with me (which evolved into partial intercourse and ejaculation) seemed to me to be part of a romanticized love affair that he envisioned between us. The effects of that notion and his deep, troubled feelings for me were harder, in the long run, to deal with than any threat of violence or physical coercion could have been. I felt I belonged to him and should be careful not to feel too much emotion for my boyfriends. I did allow myself to have feelings for them; in fact, I was extremely emotional, but I stayed within the boundaries that my father permitted. I was afraid to go beyond that point.

The first time I fell in love, I was away at college. The boy more than met any parents' requirements for being the ideal boy you would wish for your daughter. I told my parents about him when I was home on vacation. My father fell into a deeply depressed state, but I didn't associate his depression with me or my new love. I returned to college, and, two weeks later, my mother wrote to tell me that my father had been committed to a mental hospital. At the time, I didn't know that he had attempted suicide. My mother tried to keep it from me, but my parents' friends eventually told me. (Years later, my father told me himself, bursting into my bedroom during a visit I made to their house following separation from my husband.) Although I was uneasy at the time, I still didn't directly connect his behavior with the incest.

During my senior year in college, I fell in love a second time—again, with the kind of young man who would delight parents. This time I had a premonition that my parents would not be pleased to see me get so serious about anyone, even though I was 21 years old. On my graduation day, while my parents were in a pleased mood, I asked if I could have my young man visit us for a weekend. My father reluctantly acquiesced. My mother wrote my friend a formal note, telling him when to arrive and when the visit would end.

The night before the young man was to arrive, my father took my mother and me out for a lovely evening. He was always very proud of us both, and he said several times that evening, "I'm so happy to be with my two girls." We all said goodnight affectionately.

The next morning when I awoke, my mother was standing over my bed looking stricken. Our family doctor was there. I learned that my father had taken the car into the woods before dawn and tried to kill himself with carbon monoxide poisoning. A groundskeeper found him or he would have died. He was flown on a stretcher to the psychiatric ward of a clinic in another city. My mother and I spent months in that strange city, just so we could visit him for an hour each day.

I had to tell my young man that I could never see him again, let alone become his fiancee. I couldn't bear the thought that my father might harm himself again. Although my friend continued to write and call me for the next five years, hoping I'd be free to come back to him, I didn't dare respond because I'd risk upsetting my father again. I had all the guilt I could stand during those days. To add to my feelings of powerlessness, I had to stand by, helplessly, while my father underwent electro-shock treatments, which permanently impaired part of his memory.

The first evening my father was out of the hospital I asked him if he liked the new dress Mother had bought me for this special occasion. He said no, that it was far too risque for me (when, in fact, it was a very demure dress). I knew that it was just his imagination, and I also began to realize that he would continue to try to control my life, even though I was almost 22 years old. I moved away to another city in order to establish my own life.

Eventually I fell in love a third time with a fine man who

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**This story was submitted by a member of Parents United, a self-help organization for incestuous families. Parents United was originally formed as a part of the Child Sexual Abuse Treatment Program of the Juvenile Probation Department in Santa Clara County, California. There are now 28 chapters of Parents United in California. Reprinted by permission of the author. All rights reserved.**

asked me to marry him. When it was settled in our minds, I told my parents that I wanted to be married. My father was very reluctant and unhappy about my upcoming marriage, which put a damper on my whole engagement. Since I lived in a different city, I wasn't planning to see my parents until two days before the wedding. However, shortly before the wedding, in my parents' home, my father went into my old bedroom and shot himself next to the heart. As he fell, he fell onto my bed. For months, we didn't know whether he would live or die. My mother got me to go ahead with the wedding by not telling me that my father would not be out of the hospital in time to walk me down the aisle. When I found that out, I was completely devastated. I began deteriorating from that point on, obsessed with the belief that my actions had harmed my father. It is hard to describe the enormous guilt and confusion that his behavior (both sexual and self-destructive) instilled in me as a child and as an adult. Those feelings, coupled with my terror that my husband would someday discover I was an incest victim and would stop loving and respecting me, led to the first of my three breakdowns and three suicide attempts. The first occurred two years after my wedding, when I was 25 years old.

My psychiatrist's recommendation that I talk to my parents about the incest filled me with the fear that, if I confronted my father, he would try to kill himself again. In addition, I told myself that my mother couldn't handle any kind of discussion about sex; that she'd fall apart if forced to deal with the subject of incest in our family. My doctor didn't waiver from his position, however. He continued to say, "As long as you and your father try to bury this secret, it will continue to make both of you as sad and as mad as you are now. It will keep eating at both of you; it won't go away. If you can bring yourself to talk to your parents, it may free you and free them, too."

I respected and trusted this man, but I didn't believe this line of thinking. I continued to sit on the secret and work on straightening myself out with his guidance and support. I improved in many ways, but the anger and sadness stemming from the incest still spent each day and night with me. I didn't understand yet that, until I lanced and cleansed the "sore," it wouldn't heal. I just kept putting fresh bandaids on it to keep it from getting more infected.

Three years after therapy began, my doctor moved away. Therapy stopped. I tried to "go it alone." A year later, I had another breakdown. I needed more counseling. My new therapist didn't have a beard or a pipe, a booming voice or a body bigger than mine. She was my size, my sex, my age, my equal. I trusted her immensely and immediately. My transferred medical records told her about the incest, so I didn't have to. I was ready to face it and work on it once again.

You can imagine how jolted I was, just as I was easing into a comfortable and workable relationship, when what did she do? She said the same words my former doctor had said, "You keep taking out your anger and hurt on everyone . . . except your parents . . . and they're the ones who caused you that anger and hurt. Try to deal directly with them, get to that source of the anger and hurt; or it won't stop." Astonishing. I sensed some conspiracy among professional mental health helpers. I mean, where do they learn the same words? At the annual mental health conferences? These two people had never met, worked in different clinics, and were giving me the same idea. At first, it made me suspicious of both of them. Later, that sameness became the key that unlocked my disbelief and let me believe both of them. These two had helped me most; they were the two I trusted most. They hadn't steered me in any wrong directions in the past, and now they were steering me toward the same end. Could they possibly be right?

During the next four years, I studied everything I could about incest. Therapy was strengthening me so much that I finally found the confidence to say to my lady therapist, "I'm going to help other families who are trying to deal with incest." I set up my own service to help families like mine. This meant doing frightening things I had never before felt capable of—driving on the freeway and contacting people in authority (district attorneys, county supervisors, physicians, etc.). I didn't stop being scared, but I started taking action. For the first time, I believed I had something to offer, and I offered it. Counseling had helped me stop being a victim and start being a whole person. I wanted to share that with other incestuous families. I began having hopes high as chandeliers for myself and them.

One afternoon, I heard myself repeating the words of my two therapists to an incest victim who had phoned me anonymously: "The best way you could help yourself and your family is to talk with them about the sexual abuse." I believed those words. My studying and work had convinced me this was best for families whenever it's possible to do it. Now that I believed this, I knew I had to confront my own family.

I began to prepare for the confrontation. I wrote out what I would say to them, I read books about how to confront difficult situations, I talked into a tape recorder, I had imaginary conversations with them in the shower or while driving. I flew to my childhood home to talk to my parents. Within hours, I lost the courage to do what I had come for, had planned so long for. I was on their territory, became their little girl again, felt subservient to them, couldn't stand up to their united front. I became distraught. I couldn't even function normally. I had failed. I felt desolate.

That disaster was exactly one year ago. Shortly after that day, I was invited into the Parents United program, a group formed by family members who have experienced child sexual abuse. With their help, I started from Step One to prepare again for a confrontation. It took months of weekly sessions. We worked as a group, discussing it and role playing. I also talked individually to mothers and fathers in the group and to victims who had already confronted their parents. The feedback they gave me was invaluable. The fathers reiterated what I was now convinced of, "My daughter was the only one who could forgive me. Until she was able to talk about it, we couldn't rebuild the relationship we both wanted and needed." From daughters, I heard an equally important message: "Despite what other people had told me, it was only my father who could really absolve me of my guilt. It wasn't until I actually heard him take full responsibility for what had happened, that I knew I wasn't to blame." I knew that I was hearing two of the most powerful concepts in the resolution of the incest secret.

I went to my parents. I did it. This time I wasn't alone: I had brought the encouragement of Parents United with me, and I had them to return to afterwards. I could sit close to my parents and lay aside my old anger while I talked. I could talk calmly except for the few times I had to stop and wait for my voice to steady. I had prepared so long and so thoroughly that my thoughts came clearly. I was now assertive enough that they listened respectfully.

It was a devastating, exhausting day for all of us; but that's a crucial point to remember: Confrontation takes only one part of one day. It's worth it to make all the days from then on better ones. Secrets are hard on families. Opening the SECRET opens other doors, too. For instance, I was now free to tell them that I had formed my own incest help service and that I was a member of Parents United. My hope is that in the future they'll become members, too, and get help and emotional support. Now we can talk to each other without the SECRET filling the space between us like a huge air pocket, pushing us away from each other. My last words to them as we got in our separate cars to drive far from each other were, "Now I know what the word *family* really means." We'll never be as far from each other again.

## Letter To My Father

Anonymous

Dear Dad,

I do not even know how to begin, except that I will never be sorry for telling on you. You always wanted respect from me, but how do you expect respect for yourself if you are never willing to give it to another person? I think you know what I mean. It has not been easy for me either, but I didn't cop out and quit on myself. But you are, and you have always been that way. It has never been your fault for any of your wrongdoings; it's always the other guy's fault.

Daddy, you could be a very smart man if you really tried and worked at being a better person. You just need more motivation; you also need more of an education and more self-confidence. If you had these qualities you wouldn't need anyone else to lean on and decide things for you. You are a very insecure person. I always wished you could have just been my father, not my lover. I don't want you to go to prison; I want you to get better! *I swear, if you don't stay with the program you are in, I'll never want to see you again! That's a promise!*

I am going to counseling. I know it's not easy, but my counselor has helped me so much you would not believe it. Dad, I am not an angel; I know what goes on in this old world. Your problem is not an uncommon one. I also want you to know how much I love you. I love you only because you're my father, but I *hate* you for what you have done to me and are doing to yourself. You have to grow up, Dad, and take responsibility for your own actions. You ain't gonna slide through this thing like everything else you've slid through before; you are gonna get snared.

You'd better change because you desperately need help, through counseling. I don't plan on wanting to see you for a very long time—maybe never. It's mean of me, I know. But it's my turn to do it to you. Counseling alone won't help you. You alone have to decide to help yourself—no one else can make that decision. You also shouldn't dwell or ponder on the past. You should pick up from today and try and start over and do better. Dad, you'd better start admitting up to your problems. It won't be easy, I know, but once you have done it, you'll benefit from helping yourself, and you'll be one step closer to being a better person.

I want you to know that I still have my horse. I spend around $55.00 a month on him because he's my horse, not any one elses. I have a babysitting job for which I get $35.00 a week. I take care of two girls.

If you decide on going to prison, fine. Just remember, that's the way out for an ass, which is probably the way you will choose to go. Think on it!

Love,
Your Daughter

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**This letter was written by a 15-year-old incest victim to her father approximately three months after the incest was revealed to persons outside her family. Reproduced by permission of the Sexual Assault Center at Harborview Medical Center, Seattle, Washington.**

# Brothers and Sisters

**Tess' Story**

It started when I was three and it lasted until I was twelve. What my brother would do is he would say to me, "Do you want to play doctor?" And he was a great big guy. He was nine years older than I was. He was twelve. And it was just terrible. I don't clearly remember the three-year-old part. I remember when I was six.

My mother was very ambivalent. She could be very nice for a short period of time. But then she would just cut off and push me away. She's a very charming woman; she just wasn't a good mother. She should've just been my father's lover—she should never have been a mother.

She took dancing lessons and she traveled a lot with my father. Just the two of them together. And we had a bunch of servants. But it happened a lot. I can remember friends of mine—you know, also from super-rich families—where the mothers would be gone. And they'd be raised by help and be sexually abused by their brothers.

But my brother was so rough on me. He was so much bigger than I was. As a little six-year-old you don't even have any moisture or anything. It was very painful. It really hurt. I didn't yell. I kept all that inside. I didn't tell because I was too terrified. Because I felt guilty, you see.

I mean I had agreed to it. He said, "Do you want to do it?" And I had agreed to it. Because he was so big. And I would have done anything to get contact with my brother. I was much younger. And no one ever wanted to bother with me. We lived a very isolated life. This big house with a lot of ground around it. I was dependent on my brother—there was no one else to play with. I would have done anything.

My father was a very withdrawn guy. But the thing is when I grew up I had lots of dates and everything, and my parents were always very concerned about my virginity. Who I went out with. And that I married the right man. Which is so ridiculous. Here they didn't care at *all* that I lost it when I was three.

I still have a little bit of the guilt. Because even though I've been *told* that I wasn't accountable for it, that I was a child—the fact is that I agreed to it, you see. He'd say, "Do you want to play doctor?" And I'd say yes. And I really didn't at all. I just wasn't assertive enough. I mean there weren't any assertiveness-training classes for three-year-olds, for six-year-olds. And I never wanted to talk about it in therapy. And then when I got older, there was one psychiatrist who said, "Well, it was just playing doctor, you know."

But *playing* doctor implies you were playing it equally. And that's the guilt. That I did agree to it. But when you stop and think that I was only a little kid. How could I stand up to this great big brother and say no? I think that would have been a lot for a little kid that age. I wish that I had stood up to my brother. But I agreed. But I didn't like it. I really hated it.

I found a wonderful gynecologist recently. And I said, "Why did the doctors allow that to happen?" And she said, "You don't think you're the only one who went through that with gonorrhea do you?" But I guess I always thought that I was the only one.

I went back to see one of my old doctors—after my therapy. And I asked her why in the world she'd allowed this to happen. And she said, "I just don't understand your generation. You talk about sex just all the time as if it's nothing. And I just don't think that's right at all." See, she thought I shouldn't even mention it. But then I looked at the names of the doctors who had been in charge of me when I was five or six and all, and they were leading doctors at one of the best hospitals in the country. I guess it was that nobody was going to expose my father's daughter. They all wanted to be on his good side. I mean, he was the leading doctor at the hospital.

Nobody ever sat down with me. I can remember just crying and crying and crying and crying and crying. And nobody ever sat down with me and said, "Little girl, what's the matter?" Nobody. Never. Never. Never.

I know that my mother said to me once, "Your nurse says that you're into something with your brother." And I was just terrified. But that was the end of that. He was sent to a psychiatrist, but that was all. But it was still going on.

The therapist I have now works in a clinic. And he said if I had been a clinic patient even in those days, they would have blown the whistle with the first lab report and pulled in a social worker or pulled me out or done something. But the fact that I was a private patient—. He said the private doctors wouldn't try to stop something like that because—you know, they got a lot of business out of it.

But why did my mother allow it to go on? I don't understand. I don't understand. But then again, I was married to a man who was having an affair, and I look back and I say, "How could I not have known about it. It was going on under my nose. Why didn't I see it?"

I think rich people have kids as a social thing. So they can send out Christmas cards with their pictures on them. You know, they say, "Oh, we have all these children," and people say, "Oh, well, you must be a good person." But really, they have nothing to do with the children. They have servants to raise them. And then whenever we'd get too attached to the

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servants, they'd fire them. And get other servants. Jealous.

Understanding that strata—the rich WASP—it's very hard. Nothing's been written about them. They don't talk about themselves in any analytical way. But they're very isolated people. They're probably the most isolated people in the country. They have their own areas in which they live. They go to their own schools. Really, nobody knows about them.

## Barbara's Story

I'll start by telling you that I am the third oldest of ten children, and I was raised on a seventeen-acre farm not far from where I now live.

The first incident with my brother Bobbie, who was seven years older, occurred shortly after I turned six years old. I really can't remember much of what my life was like before. However, I do recall that even at that early age I knew and loved every inch of that farm. Most of my memories are of work, caring for the animals, working in the house and fields, and wandering through the woods. I have to think I was a happy child to that point.

As I recall, the first incident was just intercourse. I was six. He would have been twelve, thirteen. I remember it being terrible, painful, burning. I know I had problems after for a while going to the bathroom or whatever. Even then, though, I knew it wasn't right. I didn't know what it was. I knew it was not right because of the fact that he said I couldn't say anything. Tell on him. He said to me, "I'm going to do something. It's OK. But if you ever tell anybody, you know what I can do." And he said, "But you're going to like it." And then—that was it. And I remember crying. And I had no idea what was happening. Of course a few years later, going to school, I picked up a lot about what was happening. But I have to really say I didn't understand all of it then either. I know we got into conversations at school, like girls will. And I know from a very early age that I became terrified of becoming pregnant, knowing I wasn't old enough to do that.

Then, before he left home, I would say it happened regularly. I would say it would occur at least once a week—in the beginning—when I wasn't too clever. Later on, it was much less often. I spent most of my life finding hiding places.

I hated myself, especially at those times, later, when I was responding. I often felt, well, gee, maybe this is why it's continuing. You know? Well then—eventually—how can I say this? Eventually, does that mean that because of the fact that I no longer resisted—I mean, there was no point in resisting—does that make it OK? No longer force? Or not.

I'll tell you. I just lived in constant fear most of my life. I just didn't know which way to turn, where to hide, what to do. At that time, I didn't see how I could stop it. I don't know. All I know is from the time I was six until I was sixteen I—every day of my life—I just wanted to die. At last, Bobbie joined the army, and I could finally go to bed at night without worrying what might take place the next day.

I'll tell you what my fantasies were. I wanted to get an incurable disease. I didn't—really didn't—know how I was going to make it through this life. The only escape I had at that time was school. I really worked at school. Working, even then, as a small kid, was the only way. I kept myself absolutely frantically busy. I did most of the work around the house as a kid. My mother didn't have to ask me twice. I was there to keep myself busy, to keep myself close to her. Maybe that would help. Keep him away. I don't know what. But that's the only thing that got me through.

The other thing was I always had goals. When I was younger, I had dreams of going to school, of becoming a librarian. I was going to be a librarian at a huge library. And then, when I realized I couldn't do that—there were no finances when I was in high school—I knew I was going to have to work when I got out of school. But I spent a lot of time making sure my younger sisters had it easier than I had it.

I watched over them like a hawk. I wasn't going to let anything like this happen to them. I would say, "Nancy's six; she's ten years younger than I am. She's six years old, so now, that makes my brother Arnold twelve, thirteen years old. Do I see any signs of anything happening there?" And then I'd say, "Well, gee, Patty's now six. That means Arnold's fourteen—." So when I got out of school and I went to work, I spent a lot of money on them to help put the two of them through college. Three of them actually went to college.

See, I never told because—I just knew my parents. I knew them. I knew there was no way, even as a small child, there just was no way I was going to ever have been believed if I went to them. Plus the fact that I couldn't go because he said he would get me one way or the other, eventually. I mean I was just afraid of him, real frightened.

My mother is a very quiet homebody. She never worked out of the home. She was married when she was very young. Seventeen, I think. Just did nothing but raise a family—ten kids. She's alone now. Since my father died. He was a quiet, unconcerned man. He worked out of town five days. He'd be home on weekends—sometimes. I mean he provided for us, but he felt his responsibilities began and ended with that. As long as we ate and were clothed, that was it. He was not involved at all in raising us, except as a disciplinarian when my mother would blow her stack. After being cooped up with these kids, you know, every now and then she would really blow up. And then he would take over as disciplinarian for that one particular incident. I never had any close feelings about my father.

And see, I spent most of the time when I was real small just crying through the whole thing. I don't cry loudly. Never. I tell you, most of the time I was completely stiff when I was small—when he'd be bothering me. I mean, I just clenched my fists and cried and tried to get through it. Then later, as I realized this was going to be a regular occurrence, I just became very blah about it. Just nothing. I'll tell you what I think about it now. I don't know how I made it. I really don't.

Even now, I just do not feel comfortable around men. I have such a lousy opinion of sex right now that I just don't want it. I just want no part of it.

As clearly as I can remember, I was always introverted. I was not aggressive in any way. I think now this was partly because of the fact that my mother was very busy. I was not my mother's favorite child. I was not a cuddly kind of kid. I wasn't one that anybody really showed any affection to. Although I never showed any myself. And my parents weren't affectionate with each other. But they were with some of my sisters and brothers. My brother Bobbie was the favorite. He was six years old before the second child was born. And then of course it was bang, bang, bang after that.

One time I tried telling my mother this. "You know, I wish you wouldn't go out. Bobbie doesn't treat us right when you go out." And she said, "What do you mean?" And then I said, "Well, you know, he's too rough on us." And she said, "That can't be. He's not like that." Because he wasn't to her. I mean he could really be a very charming young man.

Later, when we were discussing this with my mother—my sister and I—I finally said to my sister, "Well, gee, how come I took most of this and you never intervened or tried to help me out?" She said, "Well, when he was at you, at least he was leaving me alone." So everybody was more or less taking care of himself. But my mother said to me, "Well, why didn't you say something to me?" I said, "Well, mom, I did try. And you said that it couldn't be. He wouldn't do something like that."

In 1976, I started psychiatric therapy. I have made some progress. I can at least look at myself in a mirror without diverting my eyes. Earlier this year, I finally removed myself from my mother's home and now live in my own apartment. I'm going to the state university nights to try for that degree I wanted as a young girl, although there are many times when I feel it is too late. Those are the pluses. On the minus side, I have no hopes of ever being able to have a meaningful relationship with a male; the nightmares are still with me; I still have difficulty thinking I'm worthy of anyone's friendship. I have negative feelings about my mother, and I still don't know what I will do the next time I face my brother.

I have no difficulty intellectualizing the situation. However, my guts won't let it go; and no matter how much I tell myself it is all in the past, there are always reminders, especially in the area of what I term a ruined life—mine.

The fact that it continued so long—. If it had been an isolated incident, especially if it had only happened when I was so young, I would have understood I had no control. But it lasted so long, and it made me feel there was something in me that made him continue. It was my fault in the sense that this continued. Plus nothing was ever resolved about it.

I never went up to him and said, "Hey, if you ever touch me again, I'll kill you." It was—a lot of defects in me. First of all, I wondered what there was about me that he picked me instead of my older sister. She was really a better-looking girl. I wasn't too attractive when I was young. I was real heavy. And I had the worst acne problem you've ever seen as an adolescent. So I'd say, "Well, gee, why me?" What was there about me—that it would be me and not her?

And I often thought: Can people see this? Is this something that shows? You know, maybe, if I get too close to someone, will they pick this up right away?

And that it would be my fault. I was supposed to be in control. It's me. It's my body. That it's only natural for a man to try, and it's up to you to draw the line.

And, of course, I never did consider marriage—because of the sex thing. I felt that there was no way I could ever become involved with a man who didn't know that something had taken place in my life. I mean, definitely I was not a virgin. And I just felt someday I'd have to explain if I ever got to that point. And not knowing how I would ever handle it, that just decided it. It wasn't for me.

I just decided I was going to be terribly self-sufficient. I just felt that there was no way I was ever going to be able to depend on anyone but myself. I'll tell you. I do have a tremendous amount of energy even now. And I really go. Sometimes I wonder if I'll run out. But I've done it for so long.

Talking about trauma, though. For—this is what?—almost thirty-five years ago that a lot of this started happening? Well, aside from how I felt at the time, in this past couple of years, the trauma I've felt is a pressure. Something that's gotten to me as if I'd come completely aware. Suddenly.

Hey. I'm forty years old.

I didn't even live.

I let it do that to me.

And then all of a sudden, I say, "Well, gee whiz, you know. Time's running out. You've got to make a start in this world somewhere."

And hope you don't run out of gas in the meantime.

# "Never Tell Anyone"

Judy's Story

written by Kee MacFarlane

I can't even remember how young I was when it started. I know that it was before I went to kindergarten. I know that it fills my earliest memories, and, mostly, it seems like it was always there.

In the beginning my father would touch me and feel me, searching my body with his hands. When he came into my room at night, I'd try to pretend I was asleep; I'd pretend it wasn't happening. It got so I didn't know what was a dream and what wasn't. Then he would take me and undress me and stand me on the table. He'd force me to touch him and do things to him. I was real young and didn't know anything. I would just cry. He'd force my mouth open with his big hand, and, when he was finished, he'd force me to swallow. I would always wait after that to die of the poison inside of me and then be surprised when I didn't.

My memory gets blurred when I try to remember the sequence of things. I know that at one point my teacher kept asking me over and over what was wrong with me, why I kept going to the bathroom all the time. Finally, I just blurted it all out. I don't remember all that happened after that. I'm told that my parents got called in somewhere, that there was a lot of talk about what should be done. I'm told that people wanted to avoid a scandal; we lived in a small city, and people wanted to keep it out of the newspapers. I'm told that he promised to go into therapy, but I never remember him going to any therapy. I don't remember that anything changed, but I do remember Thanksgiving day the year I was 11 years old.

We were going to eat dinner with the people downstairs. There was a duck in both of our ovens. My father told me to come upstairs with him and get the duck. I was afraid, but I went with him. This time, something was different. He undressed me and put me in the bed. I was scared, and I cried, but it didn't matter. As he forced himself into me, he held his hand over my mouth to keep me from screaming. I don't even remember the pain because I passed out. When I woke up, there was blood everywhere, and he was getting me up and telling me to wash. Then my mother came upstairs and saw me in the bathroom with the sheets and said, "Oh my God." I don't remember too much after that. I remember that my dad went to bed and my mother and I stayed up all night. I sat in the chair; she stood across from me doing the ironing and crying.

I guess they agreed that he would have to go away for good. Just before he left, he told me to go out into the hallway with him. My mother told me to go with him. I knew he was taking me out there to kill me because that's what he always said he would do if I told anyone. I went into the hall expecting to die, but, instead, he began to cry. I was so confused and scared. When he put his arms around my neck, I thought it was to strangle me, but he was saying he was sorry instead. I remember he told me that I would understand everything when I grew up. I never saw him again.

I thought things would get better after that. My mother told me never to tell anyone about what had happened, or they would take advantage of me. It was our secret, and I was always to keep it. But, as it turned out, other men did sexual things to me when I was young—my uncle, friends of my mother, even the man I trusted the most. At one point, this man and his wife took in my brother and me and made us feel like part of their family. He was wonderful to me; he took me everywhere and taught me all sorts of interesting things. He was the father I never had; he was a god to me; and I trusted him. The first time he put his hands up my dress, I got hysterical. I cried and begged him not to be that way. I even broke my mother's rule and told him about my father so that he would understand, so he would see why it was so important that he not do this to me, too. He apologized and held me and said that it would never happen again and that I must never say anything to his wife. But it was just another lie, and pretty soon he was acting just like before. When I left and went back to mother's, nobody could understand why. They all said it was so sudden and unexpected. His wife felt hurt that I would leave. He used to come to school and follow me around, begging me to come back so that his wife wouldn't get suspicious. I never went back, and I never had any words to explain why I couldn't.

For awhile after my father left, I thought that things would be all right at home, but then my mother's boyfriend came to live with us, and it started all over again. I thought I was living in a bad dream. No matter how much I tried to keep away from him, I couldn't; it was a small apartment, and I could never seem to escape him. I felt like I was going crazy. I couldn't stand it. As things got worse and worse, I began to dream up different ways of getting rid of Bob. My main concern was keeping my mother out of trouble; I just wanted to figure out how to make Bob go away and leave us alone. Finally, my plan was ready, and I secretly went to the police and told them that I had a girlfriend whose mother's boyfriend was doing all these things to her. I asked them to tell me how I could help her get rid of him.

The police were interested, but they kept telling me that she would have to come in herself and talk to them about it. I told them I could provide them with everything they wanted to know, and I could tell her everything they had to say. But they told me that the questions were too personal for them to ask me and that she would just have to come in herself. Finally, I couldn't stand it anymore. I told them that my girlfriend was really me and that I would talk to them if they promised not to get my mother in trouble and just take Bob aside and tell him he would have to leave. They promised to do that, so I told them everything that had been going on. I was nervous, but I felt relieved that my mother and brother and I would have a normal family back. The bad part was when the police said they would need me to help them collect more evidence in order to talk to Bob. They told me I would have to sneak in and pull up the window shade when my mother and Bob were in bed so they could take some pictures. Mom and Bob slept on the living room fold bed. I was real scared they would catch me, but I did it, and the police were out there.

Nothing happened for a while after that, and then one day all my worst fears came true. Two policemen came to the door of my school classroom and said that I had to come with them. When we got to the police station, my mother and Bob were there. They were both in handcuffs. I couldn't believe it was all happening. They were both charged with indecent nudity and neglect. They went to jail, and I went to a juvenile home. It was terrible there: peanut butter and jelly sandwiches for dinner and lots of tough street kids who were very different from me. I felt terrible; I felt guilty; and I was scared all the time. All I wanted to do was go home and be with my mother, but I felt so rotten and ashamed for getting her in trouble. When she was released, she tried to see me but I felt so guilty for what I'd done to her and Bob that I couldn't bear it.

My mother got a lawyer who came to see me at the juvenile home. He explained to me that the only way I'd ever get to go home and be with my mother would be to lie and say that I had made up the whole thing. If I didn't do that, he said they would have to lock me up forever. I didn't want to lie, but I wanted to go home so bad that it was all I could think about. He said if I could just convince them that I had lied everything would be all right, and they would leave us alone. My mother and the lawyer came and coached me about what to say at court. We went over and over it: how I had wanted Bob to buy me a dress and, when he refused, I made up the story to get him in trouble.

When we got to court, everyone was there, and I told the lie just as we had rehearsed it. As soon as I said it, it seemed like everybody in the court went crazy. Everyone was talking at once and shouting. There was a lot of talk about illegally gathered evidence, a lot of talk about me and what I'd done, and talk about a place called Clairmount. When it finally got through to me that they were going to send me there, I kept saying, "But what *is* this place? I thought that I was going to get to go home." I didn't know anything about commitments to psychiatric hospitals; I only knew that they were sending me away. And I remember my mother explaining to me that it was only for 90 days—that it was better for me to go to that place for 90 days than for her to go to jail for years.

At the hospital, I told my story over and over. By that time, I had built the lie into a forty-five minute story; even I hardly knew what was true and what wasn't anymore. I felt crazy. The doctor at the hospital didn't seem to believe my story—the same story they believed at the trial, the same story that got me there in the first place. The doctors said that if I didn't change my story they were going to give me truth serum. I didn't know what to do. I was terrified that if they gave me truth serum I wouldn't know what I was saying. I was afraid I would tell them everything and that would make it worse. I was so scared that they had to sedate me all the time to keep me calm. Finally, I decided that if I told them a little bit of the truth about what had happened they might accept it, not give me the truth serum, and let me go home. But it didn't work. Once I started talking, they said that everything would be all right, and I found myself telling them the whole terrible story about my father and Bob and everything.

I don't remember everything that happened after that. I do know that, just like all the other times, nothing worked out the way it was supposed to. The 90 days suddenly didn't matter anymore because it was decided that I was never going home again. I was 14 years old then. I was sent to a school for troubled and delinquent girls run by Episcopal nuns. My little brother also went away for awhile, and my mother was ordered not to see Bob anymore.

I stayed at the school for five years until I graduated and was old enough to get a job and be on my own. While I was in school, I was allowed to go home to see my mother sometimes on weekends, but they were weird times and made me feel like I was still crazy. I knew that Bob was supposed to be gone, and everyone told me he was, but I kept finding signs that he was still there. I would go in and find his underwear hanging in the bathroom, and my mother would tell me that they were just his old ones that she used for rags. And I was never allowed to answer the phone; whenever it rang, she and my brother would make a mad dash for it and yell for me to keep away. One time, I did answer the phone when I was home for a visit, and the person on the other end asked for Bob. My mother said I was crazy, that Bob had been gone for years. Another time, I came home early to surprise her, and I saw two shadows run past the door when I knocked. When she finally opened it, she dragged me in the kitchen, bags and all, and then I heard the front door slam. She said she didn't hear anything. When I told the counselors at school about these things, they thought I was imagining them, and sometimes I thought maybe I was.

Finally, something happened that showed that I was right about Bob still being around. My mother used to lock us out of the apartment in the morning when she went to work and told us that we could never go in when she wasn't there. She said that they would take my brother away and I wouldn't be able to visit if they caught us hanging around the area. It was a lot harder on my little brother than on me because she often forgot to come home until eight or nine o'clock at night. After awhile, he figured out a way to get in and out of the apartment when he needed stuff. He would climb up the railing on the side of the building, jump across, grab hold of the drain pipe outside the bathroom, and climb in the window. We lived on the fifth floor, and one day he missed the drain pipe and fell to the pavement below. He was just 11 years old when he died. I was at the school when they told me. The thing I remember most about the funeral was seeing Bob there holding up my mother and comforting her. Then I knew I had been right. I pulled the two nuns who had come with me over to where he and my mother were standing and said, "That is Bob." I made them promise to go back and tell the counselor that they had seen him; somehow, it made me feel not quite so crazy after all.

This is all part of a long story that I've never fully told to anyone, not even my psychiatrist. I like him, and I want to talk to him, but I guess that I'm afraid of him, too. I'm telling it now because maybe, if other people can read my story, they will know what it feels like. I want to fall in love someday and get married and have children. But I'm so afraid. I'm afraid of men, and I'm afraid to be touched. I want to be able to touch people and be touched, but I just can't bear it. I am full of confusion about myself. I feel guilty about everything and feel like somehow it all must have been my fault. I wanted a father, and I wanted to be loved, and I wanted to do the right thing. I didn't mean to get people in trouble, but I wanted them to stop doing all those things to me. I tried to do what people told me to do, but their messages were often so different.

Mostly, I just feel doomed. There must be something wrong with me; it's like I've been marked. Sometimes, it feels like there's just no point in keeping on living. It seems like it must be me and not those other people because they always seemed to pick me. Even when I was very little, it was like I was doomed. It was as if they all knew about my father. It is so hard to talk about it with anyone and so hard to understand it all. My mother always told me not to tell anyone, or they would take advantage of me. So I never did talk about it to anyone. And they took advantage of me anyway.

# Letter To The Editor

The following letter was written by eight young incest victims who were members of a therapy group in a university affiliated child psychiatry clinic. The letter was sent to the *Oregonian*, Portland's daily paper, for the purpose of persuading the public press to withhold the names of family members from news stories about sexual abuse. It was their hope that the paper would cooperate and help to publicize their desire to protect other incest victims and their families from the public embarrassment caused by insensitive media handling of incest cases.

To The Editor:

We have a group of people ranging from ages 10-14. Some of the people have strong opinions on having relatives put in the paper because of rape and child molestation. We all feel that it just punishes the victom (sic). Please keep our fathers and relatives out of the papers. All of us would like a reply. Please send a reply to our group leader.

Sincerely,
8 very upset people

Ironically, the paper would not publish their letter because of its policy against printing unsigned letters to the editor; nor did anyone have the courtesy to reply to the girls.

Diane H. Schetky, M.D. and
Bonny Boatman, A.C.S.W.
Co-therapists

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# CHAPTER XIX

# Conclusion: Aspects of Prevention and Protection

Kee MacFarlane, M.S.W.; Linda L. Jenstrom; and Barbara Mc Comb Jones

As this book illustrates, the task of protecting the child victim of sexual abuse cannot be relegated to a single professional discipline, agency, or service delivery system. Similarly, no single intervention strategy can meet the complex needs of these children and their families. Thus, there are many points of view associated with the identification and handling of cases of child sexual abuse. A number of pioneers in this field have contributed greatly to our present understanding of the problem. Nevertheless, our professional knowledge about effective case management is still in the formative stages.

Perhaps the most important step in crystallizing our understanding of and ability to deal with this subject is the recognition that child sexual abuse is not a single entity. It cannot be defined, discussed, or treated as such. Moreover, definitions of child sexual abuse will probably remain broad and somewhat diverse until its etiology is better understood and discrete typologies are developed. At the present time, we know that inappropriate sexual contact between children and adults can encompass a broad range of behaviors from subtle fondling or genital exposure, to forcible rape, to pornographic exploitation of children for commercial purposes.

Although we are a long way from having all of the answers, in the past five years many important issues have been identified and a number of myths have been challenged or dispelled. Like our knowledge about the problems of battered children, battered women, and adult rape victims, our knowledge about sexual abuse of children is expanding in defined stages. Initially, we were confronted with growing evidence of the prevalence and severity of the problem. As investigation has proceeded, we have been forced to recognize not only the fact that specialized services are grossly inadequate to meet the need, but also that existing societal institutions often unwittingly contribute to the trauma of abuse victims.

One area in which "societal abuse" can occur involves the role of professionals who are responsible for the social service and medical management of child sexual abuse cases. Inadequate training, insensitive handling, and undue emphasis on physical examination and medical evidence gathering is believed by some to add considerably to the trauma of many child victims. Reports of instances in which young children have been subjected to full gynecological examinations in cases of suspected fondling or exhibitionism or in cases reported months after the abuse occurred are particularly disturbing to those who seek to reduce the trauma these children experience. On the other hand, concerned physicians emphasize that a thorough and gentle examination often serves to calm and reassure a child that she/he has suffered no lasting damage and that her/his physical health is unimpaired.

As the need for specialized services and specially trained professionals becomes more apparent, a number of issues and questions emerge that are particularly relevant to service providers and to those who seek to protect children from sexual exploitation. Although there are a number of similarities in the procedural handling of all types of child sexual abuse cases, there are also important differences in the type and extent of therapeutic intervention required to alleviate the effects of various forms of abuse. For example, all sexually abused children should have the benefit of a thorough, atraumatic diagnostic evaluation that is atuned to their needs and concerns. In addition, they should receive treatment from patient, sensitive, and specially trained personnel. However, differences in the situational dynamics of a sexual assault by a stranger and sexual abuse by a close family member have critical implications for treatment.

In most cases, the sexual assault or molestation of a young child by a stranger acts as a catalyst for family support of the child and attention to her or his immediate needs. This is not to say that all families are able to cope appropriately with feelings of rage, fear, or guilt that may be aroused. However, for the most part, these families are unlikely to blame the victim for the incident, particularly if the child is very young. Usually, the family's efforts are directed toward child protection and reassurance. In such cases, crisis intervention techniques that seek to return the family to its previous state of equilibrium are often the most appropriate and effective means of intervention. These techniques, as described in Part I of this book, constitute a relatively short-term form of family treatment. Their primary purposes are to provide immediate medical care for the child and emotional support for the child and family, to help parents put the situation into perspective, and to ensure that there are no underlying family needs or problems that might contribute to a recurrence of abuse.

The dynamics of incest or intrafamily sexual abuse are considerably more complex and difficult to treat. Although these cases are often less violent and may not be perceived by the child as immediately traumatizing, public discovery of parental incest usually produces an acute family crisis. The initial symptoms and reactions resulting from this crisis may parallel those that are common in cases of assault by a stranger. Therefore, the same types of crisis intervention techniques are often useful during the initial intake period. However, the underlying, interpersonal dynamics that brought the situation to a crisis point usually indicate the need for more intensive intervention.

Incest appears to be associated with a high degree of family disorganization or disharmony. Therefore, there is no preexisting state of healthy family equilibrium that can serve as a treatment goal. Because such cases are often brought to the attention of authorities through the actions of the child rather than at the instigation of the parents, the child may be perceived by other family members as a betrayer. Consequently, the primary family reaction may be one of rejection toward the child and protection of the offender. In addition, family members may have a variety of self-focused concerns, including the very real possibilities, mentioned previously, of family disintegration and economic or emotional loss resulting from imprisonment of the father or father figure.

From the standpoint of the treatment provider, there may be no family member available to provide needed emotional support and future protection for the child. In addition, rather than viewing medical and social service professionals as sources of help for themselves and their child, adult family members may view any intervention as an unjustified and hostile invasion of the family's privacy. For the child, sexual exploitation by a parent or parent figure is a fundamental betrayal of childhood trust by a person who is also seen as a necessary protector. Yet, children who have been sexually abused by family members often present extremely ambivalent feelings when confronted with the authority of intervening professionals. It is important to remember that most maltreated children want the abuse, not their families, to end.

In addition to individual professional services designed to meet medical, social, and emotional needs of families in crisis, many programs have begun to emphasize the use of group counseling with incestuous families. Various applications of the self-help concept in combination with a humanistic, nonjudgmental approach to therapy are showing that groups of mothers, fathers, couples, teenagers, and entire families can do a great deal to reduce the isolation, family disruption, and other detrimental effects associated with intrafamily sexual abuse. Such programs also serve to highlight the more practical financial and legal needs and problems of these families, which may be overlooked in more traditional medical or counseling settings.

While there is much need and room for improvement in medical and social service treatment of sexual abuse victims, when these children are confronted by the demands of the law enforcement system, they may suffer yet more emotional trauma at the hands of society. Of particular relevance is the differential way in which society treats children who enter the criminal justice system. As Berliner and Stevens note in Chapter X, the United States was the first country to establish a separate justice system for juveniles. Unfortunately, however, the juvenile justice system is only designed to protect children accused of commiting criminal offenses. Surely, children who are victims or witnesses of adult crimes are in need of at least as much special consideration. Yet, this is not the case.[1]

When a case of sexual abuse is reported, a series of investigative, protective, and/or prosecutorial procedures follows inexorably. Regardless of the type of legal remedy undertaken, such intervention can, and often does, have a devastating impact on the child and family. Whether or not the case goes to trial, the child may be repeatedly required to describe the details of the incident to many different professionals. If a trial does result, the trauma a child may incur while giving evidence in open court against a stranger pales when compared to the potential trauma of the incest victim testifying against his/her father or other close family member.

Recognition of this has led to a sharp difference of opinion among some professionals concerning the appropriate course to follow in managing cases. Debate has largely centered around the advantages and disadvantages of involving an incestuous family in the criminal justice system. Proponents argue that there is a strong need for legal intervention because few incest offenders are willing to enter or remain in treatment without the threat of conviction. They believe that the introduction of judicial authority into the family context provides the leverage necessary to work successfully with resistive families, and that the courts still offer the most effective way to stop child sexual abusers from re-offending. Finally, although temporary placement of a child is often necessary during the initial stages of investigation, proponents of criminal justice intervention argue that if a member of the family must be removed from the home for any lengthy period of time in order to ensure that the abuse is stopped, it is usually in the child's best interests that the offending adult be the one to go.[2]

Opponents of the criminal justice system's handling of incest cases are equally adamant about the need to keep intrafamily sexual abuse cases out of that system whenever possible. They are unwilling to initiate a legal process that may place a child in the position of having to testify at an open trial, a stressful experience even for adults. For children, such experiences can represent a nightmare that may haunt them long after the memories of the abuse have subsided. The legal process can quickly develop into an adversarial proceeding between child and adult, and often acts to entangle the entire family in a web of recrimination which can jeopardize any future chance for family rehabilitation or marital reconciliation.[3] Finally, as many have noted, jailing the offender is too often confused with treating the problem. Needless to say, there are few rehabilitative facilities for incest offenders, and their pariah status in prison often places them in physical danger from other inmates.

Recognition of the pervasive nature of societal abuse in the management of child sexual abuse cases demands coordinated, remedial action on the part of a wide range of professionals in every community. Increased training is needed for special teams of professionals to deal with sexual abuse of children in hospitals, police departments, courts, and social service agencies. More and better specialized treatment programs or program components must be established. Research investigations into the nature, extent, causes, and consequences of child sexual abuse must be expanded.

Almost without exception, the reported incidence of child sexual abuse has risen dramatically in those places where there are specific, well-publicized programs to deal with the problem and where people are helped to overcome their fears of coming forward for assistance. Some programs report that they have experienced as much as a 400 percent increase in cases as the availability of their services becomes known in the community. Professionals working in these treatment programs report that they receive calls and letters seeking help from families all over the country.

While it is essential that we proceed to institute needed changes throughout our health, legal, and social service systems, we must also recognize that these efforts constitute only secondary prevention; that is, prevention of additional trauma to a child who has already fallen victim to sexual abuse. Finding ways to ensure the *primary* prevention of sexual abuse of children remains a formidable challenge. Although the state of our present knowledge is not sufficient to permit the development of a prescriptive package for prevention, we can work to bring about a substantial reduction in the sheer numbers of children who are subjected to such abuse each year. This kind of prevention requires active outreach and education.

Children need to develop a healthy, consistent code of sexual conduct. This is a gradual process of maturation which usually unfolds within the confines of prevailing family and societal attitudes and standards. To set appropriate limits for their children's behavior, parents need to know more about normal childhood sexuality and sexual development. They also may need assistance in handling their own sexual feelings appropriately. When parents are ill-informed or experience conflicts over sexual matters, they may knowingly or unknowingly communicate ambiguous messages to their children. For example, parents may unwittingly encourage provocative and coy behavior in their daughters by allowing access to sexually stimulating reading materials, television, or movies; by exercising little supervision over their social relationships; or by permitting wide latitude in matters of dress or curfews.[4] Parents may subtly encourage young girls to grow up fast and to learn to use their "wiles" to their advantage. When adult sexual behavior is encouraged in young children, they may become confused about the appropriate purposes and functions of their sexual feelings. This confusion may leave them vulnerable to sexual encounters for which they are emotionally or developmentally unprepared.[5]

Similarly, young boys may be prey to sexual victimization. The available data on reported cases of child sexual abuse has lent credence to the notion that few boys are victims. Yet, special service programs for sexually abused children report that they are seeing increasing numbers of boys. Many believe that young boys are far less likely to report an incident of sexual abuse, even to their parents. Boys are, after all, often raised to be "little men" and to fend for themselves. Since most victimization of boys involves male offenders, they may feel an increased sense of shame or guilt, making them doubly motivated to keep the abuse a secret. When young boys do report an incident, helping professionals and police are sometimes less inclined to treat the matter with the necessary tact and sensitivity. This may result from a tendency to believe that the feelings of little boys are less fragile than those of little girls.

Unfortunately, children are often raised with inappropriate expectations about both male and female sexuality. Society too often reinforces the ideas that sexual pleasure may be taken by physical force or coercion or that women and children "ask for" sexual exploitation in their behavior or vulnerable status. Children must be helped to develop the values and expectations that will not allow them to objectify others to the point of exploitation.[6]

While informed and sensitive parents can establish an atmosphere conducive to healthy sexual development, children also need specific, factual information about sex and sexuality. Children's questions usually indicate what they want to know. Responses that incorporate too much detailed information may only be confusing or frightening. For example, a young child who asks, "Where did I come from?" may be wondering whether he was born in Denver or Dallas. If a conscientious parent replies by describing the entire reproductive process, the child will be none the wiser.[7] Conversely, when children *do* ask for factual information about sex, they need and deserve honest, simple answers that are geared to their level of understanding.

Even when parents readily provide basic sex education to their children, they may be reluctant to discuss the nature and indicators of sexual abuse. However, this educational component is an essential part of primary prevention. If children are taught what constitutes appropriate adult-child physical interaction (regardless of who the adult may be), they are in a better position to prevent or at least seek help for their own victimization. As one former sexually abused child poignantly said, "They told me never to accept rides or candy from strangers, so I never did. They never told me to watch out for my own father or why." [8]

Information about sexual abuse can be presented to children in the same way they are told about other sexual matters. With young children, it is usually best to explain sexual assault in the context of other general dangers, such as playing in the street. Older children (latency-age) need more information and can usually understand if sexual abuse is presented as a problem found in some troubled adults. They can be told to avoid or leave any situation that seems strange or uncomfortable to them. The increasing independence of adolescents may make them particularly susceptible to sexual exploitation. Open discussions that focus on specific problems and concrete situations may offer the best protection. Teenagers benefit far more from realistic discussions of the pros and cons of potentially dangerous activities than from blanket prohibitions.[9]

One of the most important aspects of prevention involves teaching children to differentiate among adults. Children tend to perceive anyone older than themselves as superior and authoritative. They must be helped to learn that there are acceptable degrees of compliance and respect and that not all adults are worthy of their trust. Children must be taught that their bodies are their own and that they have the right to exercise control over them. It is of utmost importance that children be taught that they have the right to say no to anyone in matters of sexuality.[10]

Finally, because children naturally defer to authority figures, they need to be assured that their efforts to resist victimization will be supported by others. If they find that they are inadequately protected in their own homes, they need to know that outside sources of help are available. For this reason, all adults who regularly interact with children have a responsibility to be alert for the visual signs and halting messages of children in trouble. Children can only be as strong and effective in their own defense as the adults who stand behind them.[11] In the words of Erik H. Erikson:

*"Someday, maybe, there will exist a well-informed, well-considered, yet fervent public conviction that the most deadly of all possible sins is the mutilation of a child's spirit; for such mutilation undercuts the life principle of trust, without which every human act, may it feel ever so good, and seem ever so right, is prone to perversion by destructive forms of consciousness.*[12]

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# APPENDICES

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# APPENDIX A

# Hospital Protocols for the Diagnosis and Treatment of Child Sexual Abuse

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# Emergency Room Protocol For Sexual Assault: Child and Adolescent Patients

**Sexual Assault Center**
**Harborview Medical Center**
**Seattle, Washington**
**December 1978**

**INFORMATION FOR ALL INVOLVED WITH PATIENT:**

1. See immediately. Even though no physical trauma may be present, victims of sexual assault should receive high priority (immediately following acutely ill or injured patients).
2. Provide maximum support to parents as well as to the child/adolescent victim. Do not be judgmental nor allow emotional responses (e.g. anger, outrage) to interfere with providing optimal care.
3. Only those DIRECTLY involved in care should talk with the patient; give the patient and parents your name and explain your role.
4. Do not discuss sexual assault cases with anyone without the consent of the parent or legal guardian and the patient, if an adolescent.
5. "Rape" and "Sexual Assault" are legal, not medical, terms. Do not use other than as "History of Sexual Assault."
6. The chart may be legal evidence. "Hearsay" statements from those who first see the child/adolescent may be admissible in court. All statements should be accurate, objective, and legible.

**EMERGENCY ROOM PERSONNEL:**

1. Provide private facilities for the victim (ER 9 or the Quiet Room). Complete registration there.
2. Contact the ER physician immediately if there is evidence of moderate to severe physical trauma.
3. Obtain consent for care from the parents or legal guardian. If such consent cannot be obtained, contact the hospital administrator or the Juvenile Court for temporary consent. Examination of the adolescent should not be done without her/his consent unless a life-threatening emergency exists.
4. Contact social worker immediately.
5. If the assault occurred within the past 48 hours, contact the pediatric resident immediately. If the assault occurred more than 48 hours ago, the social worker will ascertain need for medical care.
6. The sexual assault tray and vaginal kit (containing Pedersen and pediatric specula) should be placed in exam room. (Check and replace items daily.)
7. Chaperone pelvic examination. A female chaperone (hospital employee) should be present for all pelvic examinations. Do not have the patient undress until just before the physical examination.

**SOCIAL WORKER:**

1. Assess immediate emotional needs of child and parents. Respond appropriately.
2. Confirm that the pediatric resident has been notified.
3. History: Obtain alone or in conjunction with the physician.
   a) Ascertain as much of the history as possible from parents or accompanying persons first, away from patient.
   b) See patient alone to obtain history (unless parent or other person is needed for support, i.e., in the very young child).
   c) Determine and use the patient's terminology for parts of the body, sexual acts, etc. Use aids, i.e., toys and picture books, as needed. Questions should be appropriate for age and developmental level.

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   - d) Obtain a directed history of the assault. Do not ask "why" questions, e.g., "Why did you go to his house?" Phrase questions in terms of "who, what, where, when," e.g., "Did the offender use oral, finger, penile contact to mouth, vulva, vagina, rectum?"; "How long ago did it happen?"; "Did penetration or ejaculation occur?"; "What kind of force, threat, or enticement was used?"; "From whom did the patient seek help?"
   - e) When the physician arrives, present history and impressions (out of patient's hearing) and complete history-taking conjointly.

4. Explain to patient and parents the reasons for questions asked, types of medical/legal tests needed, and possible treatment.
5. Obtain special consents, i.e., for photographs, release of clothing, release of information (specify to whom).
6. Assist with the physical examination, if indicated.
7. Discuss reporting to police and/or Children's Protective Service. Police may be contacted to come to the Emergency Room for an initial report.
8. Assessment and Counseling:
   - a) Assess behavior and affect. Ascertain support systems of patient and family. Do not return child home unless the environment is safe. Document changes in housing.
   - b) Explain anticipated emotional problems. Give patient and parents SAC handout.
   - c) Encourage consulting with the Sexual Assault Center.
9. Record on Sexual Assault Report form services offered to patient:
   - a) Medical appointment for follow-up care.
   - b) Ongoing counseling or advocacy by SAC.
   - c) Children's Protective Service referral, when indicated. (Referral to CPS is legally mandated when the offender is a family member or when the home environment does not protect the child from further sexual abuse.)
   - d) Referrals made to other agencies.
   - e) Victim's Compensation brochure, form, and brief explanation.

**PHYSICIAN:**

1. Medical History: Ascertain history from social worker and parents. Corroborate with patient. Do not needlessly repeat questions. Use "History of Sexual Assault" form #0245.
   - a) Use vocabulary appropriate for age and developmental level. Use patient's words to describe and explain meaning if needed, i.e., "He put his 'thing' in me." (penis). Use picture books or toys as aids as needed.
   - b) Ascertain activity post-assault: changes of clothing; bathing; douching; urinating; defecating; drinking.
   - c) Obtain menstrual, contraceptive, VD history as needed.
   - d) Obtain pertinent medical history: chronic illnesses; allergies; etc.
   - e) Discuss VD prophylaxis, hormonal pregnancy prevention and abortion. Ascertain patient's feelings in these areas.
2. Approach to Examination:
   - a) Be gentle and empathetic. Explain what you are doing in a calm manner and voice. Take time to relax the apprehensive patient.
   - b) If supportive, have parent stay with child during the examination. Allow the adolescent the option of having whom s/he wishes to be present.
   - c) Allow the patient to feel as much in control of his/her body during the exam as possible. Verbalize an understanding of his/her anxiety.
   - d) Use appropriate gowns and drapes to ensure modesty and decrease feelings of vulnerability.
   - e) Unless there is physical trauma which is apparent or must be ruled out, the complete examination does not need to be done (i.e. use of stirrups, speculum). All tests can be done with a glass pipette and cotton swabs. 1) A small child may lie across the mother's lap in a "frog-leg" position. 2) An older child may lie on the exam table in the same position. 3) An adolescent may lie on the table in the same position or in stirrups.
   - f) Use a REASONABLE approach. Use only those parts of the protocol appropriate for age of child and type of assault.
3. Physical Examination: Perform with hospital employee as chaperone.
   - a) General: Document emotional status; general appearance of patient and clothing.
   - b) Document areas of trauma on TRAUMAGRAM and describe in detail.
   - c) Examine areas involved in sexual assault, i.e., oral, vaginal, rectal, penile. Very carefully document even minor trauma to these areas. Photograph areas of trauma as indicated (per Photography Protocol).

d) Ask patient to point with finger to exact area involved. Ask how much further offender penetrated.

e) Describe developmental level (Tanner Stage), external genitalia, type and condition of hymen and diameter of introitus.

f) Do exam as indicated by age of patient, type of assault and degree of injury. If injuries are extensive or cannot be determined due to lack of cooperation, consider examination and treatment under general anesthesia.

4. Medical Tests:
   a) Culture body orifices involved for gonorrhea. If history is uncertain, culture all orifices.
   b) Obtain gravindex to rule out pregnancy as indicated.
   c) Obtain VDRL baseline. May be deferred in the young child or apprehensive adolescent.

5. Legal Tests:
   a) UV light—semen fluoresces. Examine areas of body and clothing involved (in dark after visual adaptation).
      1) Save clothing fluorescing for police (as per clothing protocol).
      2) Swab body areas fluorescing with saline moistened swabs. Place swabs in red top tubes. (Follow Evidence Collection Protocol.)
   b) Wet mount preparation:
      1) Aspirate or swab areas of body involved (pharynx, rectum, vaginal pool). Saline moistened swabs may be used; however, aspiration with a glass pipette after flushing area with 2cc. of saline is preferred.
      2) Place drop of secretions on glass slide, plus drop of saline; examine immediately.
      3) Physician should examine several fields under high power with light source turned down. Document presence or absence of sperm and number of motile/nonmotile seen per high power field.
   c) Permanent smears:
      1) Physician will make two preparations. One slide will be a routine PAP from the endocervix and vaginal wall areas (may be deferred in child). The second slide will be a smear from the posterior vaginal pool, rectum, pharynx as indicated. Obtain in the same manner as the Wet Mount.
      2) Put both slides promptly into the PAP bottle, back to back. DO NOT ALLOW TO AIR DRY. (Follow Evidence Collection Protocol.)
      3) Physician will complete and sign PAP form noting "History of Sexual Assault; please do routine PAP and document presence or absence of sperm."
   d) Acid Phosphatase:
      1) Collect in same manner as for wet mount preparation.
      2) Place saline moistened swabs or secretions from pipette in red top tube. (Follow Evidence Collection Protocol.)
   e) Other tests—as indicated or as police request (mainly to identify assailant), i.e., ABO antigens (collect as for acid phosphatase); fingernail scrapings; pubic hair combings.

6. Treatment:
   a) Injuries—treat and/or consult with other specialties as indicated. Give tetanus prophylaxis as indicated by history; follow CDC-Public Health recommendations (available in ER).
   b) Pregnancy prophylaxis—may be given IF a vaginal assault occurred at midcycle, without contraception, and patient understands risks and side effects of estrogens to be given and is willing to have an abortion should pregnancy occur despite medication. *Do not prescribe* if there has been other unprotected intercourse during this cycle or any possibility of pre-existing pregnancy. Obtain a negative gravindex before instituting therapy.
      1) Hormonal therapy—Estinyl: 2.5 mg b.i.d. for 5 days OR stilbesterol: 25 mgm b.i.d. for 5 days (Prepacks in ER).
      2) Antinauseant therapy—Bendectin (ii h.s. as needed for nausea and vomiting). Give routinely to use as needed (Prepacks in ER).
   c) VD prophylaxis
      1) Not given routinely but as indicated, e.g., high patient anxiety, possibility patient will not return for follow-up care, known disease, multiple rapists.
      2) Therapy (over 12 years of age):
         a) Probenecid 1 gm orally + Ampicillin 3.5 gm orally stat; OR
         b) Probenecid 1 gm orally followed in 30 minutes by procaine penicillin G 4.8 million units IM; OR
         c) If penicillin allergy, spectinomycin 4 gm IM OR tetracycline 1.5 gm stat and 500 q.i.d. x 4 days.
      3) Therapy (under 12 years of age): use age and weight appropriate dosages.
   d) Treatment for anxiety and/or difficulty sleeping—as indicated (rarely needed in children under 12 years; use age appropriate dosage when given). Adult therapy as follows:

        1) Mellaril 10 mgm one-half hour before sleep (may repeat once, if necessary; do not exceed 20 mgm/day. Give a 3-day supply (60 mgm); OR
        2) Valium 5 mgm one-half hour before sleep (may repeat once p.r.n.). Do not exceed 10 mgm/day. Give 3-day supply (30 mgm).

7. Final Care
    a) Verbally express concern and availability for help as needed.
    b) Reinforce social worker information; reinforce that patient is physically intact and is not responsible for the assault/abuse.
    c) Discuss medical problems which may arise and encourage family to call as needed.
8. Final Diagnosis
    a) History of Sexual Assault.
    b) Presence or absence of sperm.
    c) Specific diagnosis of injuries, contusions, lacerations, etc.
    d) Other pertinent medical diagnoses.
9. Follow-up
    a) Pediatric Clinic appointment in one week.
    b) Repeat gonorrhea cultures at follow-up visit; VDRL in 8 weeks; other as indicated.
    c) Consultation from other specialties as indicated.

# Incest and Other Family Related Sexual Abuse Cases: Physician's Guidelines to Management

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**November 1977**

Sexual abuse of children by parents or caretakers includes incest (sexual intercourse), sodomy (anal intercourse), oral genital contact, and molestation (fondling, masturbation, digital manipulation, etc.)

Most of these incidents occur without force. By contrast, rape usually is defined as sexual intercourse (a) forced upon a victim using violence or threats of harm and (b) with a stranger as the offender. All family-related cases of incest and all molestation cases, should be evaluated by the pediatric house staff. Rape cases (except in emancipated minors) should also receive a brief workup by the pediatric house staff before requesting gyn-consultation. They should be seen promptly, since the family usually looks upon the situation as an emergency. The following guidelines are recommended for the pediatrician:

1. *Protect the Patient from Additional Emotional Trauma:* Victims of rape or other sexual assault are usually in serious emotional distress upon arrival in the emergency room. (By contrast, victims of chronic incest or molestation may not be upset.) Before any examination takes place, they should be allowed to ventilate about what has happened to them. If possible, a woman resident should be assigned to cases that involve female victims. If the physician doesn't have time to deal with these aspects of the problem, crisis counseling should be provided by a Child Welfare worker, clinic social worker or psychiatrist on call. The patient should not be asked to disrobe until after she is feeling better. The pelvic exam should obviously be preceded by careful explanation and humane preparation by the clinic nurse, especially if it is a first one.
2. *Elicit a Detailed History of the Incident:* Documentation of sexual abuse is usually totally dependent upon the history. Therefore, the interview needs to be long, relaxed, and tactful. The patient describes symptoms that could be related to sexual abuse, the story must sometimes be drawn out by a question such as, "I have a feeling that maybe somebody has done something to your body that has frightened you. Why don't you tell me about it?" The child's special names for body parts will often be helpful. In addition to facts regarding date, time, place and person, the physician must document sites of sexual abuse (e.g., mouth, breasts, genitals, anus). Also, information on menstrual history, whether or not force was involved, the patient's concept of intercourse, whether or not penetration occurred, and whether or not ejaculation took place should be sought and recorded. In children under age 6, this information usually will have to come from the mother or other adult. Older children should be encouraged to tell their own story in a private setting. (*Note:* In true rape cases, the gyn. resident will elicit this history.)
3. *Perform a General Physical Examination:* The patient needs a general physical exam to look for any signs of body injury or infection. The mouth, anus and external genitals should receive special scrutiny for signs of trauma (i.e., redness, abrasions, purpura, petecchiae, tears). The hymenal ring should be inspected for size, fresh tears or old scars.
4. *Lab Studies on Cases Not Referred to Gynecology:* The pediatric resident should check molestation cases for the presence of sperm even in the absence of a history of ejaculation. A moistened cotton-tipped applicator can be inserted into the vagina and then spread on a slide. The finding of vaginal discharge or an inflamed throat should lead to a culture for gonorrhea. Any history of anal manipulation should lead to a sperm test and gonorrhea culture of this site.

**The authors are members of the staff of the National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver, Colorado. Reprinted by permission of the authors from GUIDELINES FOR THE HOSPITAL AND CLINIC MANAGEMENT OF CHILD ABUSE AND NEGLECT, available from NCCAN.**

5. *Refer Selected Cases to Gynecology for a Forensic Vaginal Exam:* The gynecology resident on call to the ER has the expertise to perform a forensic vaginal exam that can stand up in criminal court. All rape cases (post-pubertal or pre-pubertal) should be referred to gynecology. Incest cases can be referred if intercourse has taken place in the last 72 hours, or this exam can be performed by the pediatric housestaff. (Evidence for sperm rarely persists beyond this time period.) Obviously, molestation cases do not need a gynecology referral.

   The gynecology resident will usually collect the following evidence: (1) any stained clothing, (2) wet smear for sperm (examined in the ER), (3) dry smear for sperm, (4) vaginal swab for acid phosphatase), (5) gonorrhea culture, (6) blood type of victim, (7) VORL on victim, (8) pubic hair specimens, etc. All specimens must be carefully identified with the patient's name and then placed in a *sealed* envelope. The sealed envelopes must be given to the investigating police officer for delivery to the state Bureau of Investigation Laboratory.

   Cases at-risk for pregnancy should receive prophylactic stilbesterol, 25 mg. b.i.d. for 5 days, assuming evidence exists that the patient is not pregnant. Cases at-risk for venereal disease should receive 1.0 gm. of probenicid plus 4.8 million units of procaine penicillin IM or 3.5 gm. ampicillin p.o. The gynecology resident usually will attend to these matters.

6. *Hospitalize Selected Cases:* The immediate objective in sexual abuse cases is to prevent continued sexual exploitation of the child. This usually requires placing the child in a foster home and getting the parents into therapy. In cases where Child Welfare accompanies the family, the above actions usually can be arranged quickly. In cases where the parents or girl present themselves initially to the hospital, without any prior agency involvement, the best course of action usually is to hospitalize the girl until Child Welfare can become involved.

7. *Request a CPT Pediatric Consultation on Difficult Cases:* Many of these cases are difficult. To avoid repeating the history or exam, call in the CPT consultant or ER attending before beginning your history.
   a. Weekdays—Call Dr.____________(Extension____________) or the CPT office (Extension____________) on all cases for consultation.
   b. Evenings and weekends—Call the ER attending on *all* cases. If the ER attending feels that the diagnosis is definitely confirmed and will not need an expert witness in court, CPT consultation is unnecessary. If the attending feels the diagnosis is uncertain *or* the case is complex and may require an expert witness in court, call Dr.____________at the home number posted on the CPT consultation list.
   c. Always *SAVE* the chart for the CPT, so that a typed report can go in within 48 hours.

8. *Request a CPT Social Worker Consultation on Selected Cases:* In general, the psycho-social evaluations in these cases will be done by a Child Welfare worker. However, if they do not accompany the patient, call our CPT social worker (Extension____________). Another reason for consultation might be where the police and Child Welfare social worker are going to return the child home, but you feel that temporary foster care is necessary for the child's safety. On weekends and evenings, if you need a social worker, phone the on-call Child Welfare worker in the county of residence. (See that list.)

9. *Complete an Official Written Report of the Sexual Abuse Incident:* The case should be reported to Child Welfare by phone immediately, and this will be done as soon as you notify the CPT Coordinator (____________). The official medical report is required by law within 48 hours and should be written by the examining physician. As long as the medical record of the clinic visit contains the following data, the official typed medical report can be extracted from it. (See sample.) After completing your chart note, give the chart to Dr.____________or the CPT Coordinator immediately. On the weekends or evenings, *SAVE* the chart until the next working day. We have no facility for typing these reports during evening hours. The report should include:
   a. History—the alleged sexual abuse incident (with dates, times, places, sites involved, people involved, etc.)
   b. Physical exam—description of any positive findings or pertinent negative findings. (Use nontechnical terms as much as possible.)
   c. Vaginal exam by gynecology consultant—if done, list his name here.
   d. Conclusion—concluding statement on reasons why this represents sexual abuse.

10. *Provide Follow-Up Appointments:* The hospital CPT will become involved as soon as notified and arrange to have all female siblings interviewed to rule out the possibility of any similar incidents with them. If supportive counseling has not been provided by a mental health professional in the emergency room, the girl will be referred to such a person for evaluation as soon as possible after the incident. If the patient is post-pubertal and runs any risk of becoming pregnant, she should have a one-month follow-up appointment in the Adolescent Clinic to see a physician.

# SAMPLE

## SEXUAL ABUSE MEDICAL REPORT

*PATIENT'S NAME:* T.L.
*BD:* 6/12/67
*CGH#:* 222333

*History:* This 7-year-old child was brought to Colorado General Hospital 8/20/74 by her mother because of concern about sexual molestation of the girl by her husband (girl's stepfather). The mother is worried this has been going on for 6 months and quite frequently. The following history is directly from the mother. In the past two weeks since the mother quit work, the little girl, Tracy, has been coming to her to say such things as "Daddy tickles my bottom with his tongue, then he potties on me." (Interpretation—oral-genital contact and ejaculation.) The mother states that she has found the stepfather and daughter lying together on their bed and both have jumped when she walks in. The mother came in today because last night Tracy told her that her father "tickled my bottom with his finger" while the mother was at the laundromat. She says she wants her husband and/or daughter to get help and she has confronted her husband with this. He denies molesting Tracy, but says he will go to get help for himself. The girl is unwilling to talk to the examiner. However she says "yes" when questioned about her mother's story. She denies that her father has ever put his penis in her bottom.

*Physical Exam:*

No signs of physical abuse. No signs of genital trauma. Hymenal opening intact and virginal.

*Conclusion:* This 7-year-old girl has been repeatedly sexually abused by her stepfather. This includes oral-genital contact and other forms of molestation. Urgent intervention is needed.

(date) ______________________________

M.D.

## KEY FOR TRIAGING CHART

1. Emancipated minor—by *Colorado* law, for example, any person 16 years of age or older who lives separate from parents and makes his/her own financial decisions.
2. Incest—sexual intercourse between family-related adult and child. (Anal intercourse and oral intercourse should also be evaluated according to these guidelines.)
3. Child molestation—sexual contact other than sexual intercourse (e.g., fondling, masturbation, exposure).
4. See GYN. Protocol: "The Management of Patients Who Have Been Sexually Assaulted."
5. See Ped. Protocol: "Incest and Other Family-Related Sexual Abuse Cases: Physician's Guidelines to Management."
6. Page the GYN-resident (______________) to come to the Pediatric Clinic.
7. Weekdays: The CPT Coordinator will do this. (Extension____________). Evenings or Weekends: Call the Child Welfare social worker on-call in county of residence—posted on bulletin board. *SAVE* chart for CPT Coordinator.
8. Days: Adolescent Clinic social worker for all.
   Nights and Weekends: If distraught, child psychiatrist on-call.
   If stable, reappoint to Adolescent Clinic.
9. Days: CPT social worker for all. (Exception: Child Welfare social worker accompanies the patient.)
   Nights and Weekends: Call Child Welfare social worker in county of residence or get a consult from someone on CPT.
10. Leave name and phone number for Adolescent Clinic social worker (room________). She will set up an appointment.
11. a) ER Rape Counselors. Call the charge nurse in the ER for the name and phone number for the on-call person. They will come in and provide crisis counseling. *OR*
    b) York Street Center. Call_______________. Free crisis counseling is available 24 hours a day, 7 days per week. This agency will also help with transportation, a safe place to stay and legal problems.

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# Medical Management of Sexually Abused Children and Adolescents

**QUEEN'S BENCH FOUNDATION**
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## GENERAL DESCRIPTION

### I. *OVERALL OBJECTIVES*

- To care for the acute medical problems of the child.
- To care for the acute emotional problems of the child and family.
- To safeguard the child from any threat of further sexual abuse.
- To formulate plans for comprehensive follow-up medical and psychological treatment for the child and family.
- To comply with legal requirements.

### II. *PSYCHO-SOCIAL CONSIDERATIONS*

Sexual abuse of the child can be any type of physical or sexual intrusion. The severity can range from simple fondling to the act of penetration. More often than not, the offender is known to the child, whether a family member (incest) or close friend.

Sexual abuse of a child may produce acute and long-term emotional consequences for both the child and his or her family. To effectively care for the acute emotional problems and minimize the long-term psychological consequences it is necessary that hospital staff treat the child and family with sensitivity and compassion. The management of every abused child must be

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individualized. For some children, the experience can be emotionally devastating, while for others it may be of only minor consequence. The child's age, degree of comprehension of the abusive act, discomfort from the sexual act, or trauma from the subsequent physical examination or interview are significant factors which may determine the impact of the events on a child. All efforts should be directed to minimize these adverse psychological effects by treating the child gently and compassionately, and by remaining calm throughout your encounter with the child.

Also important is the matter of dealing with family members. Often, the anguish and anger of the family will exacerbate an already difficult situation for the child. The emotional stability of the child depends, to a great extent, on the emotional stability of the parents. Great care should be exercised in your initial dialogue with family members to establish trust and open lines of communication.

*A careful recognition of family dynamics is especially important in cases where incestuous activity is suspected.*

No protocol can cover or teach the skills necessary to deal with an abused child and his or her family. However, an awareness of the psycho-social considerations in dealing with sexually abused children is essential if you seek to deliver services with compassion and understanding.

## III. *PRE-EXAM PROCEDURE*

It is essential to keep in mind that whether sexual assault has or has not occurred is a legal matter and not a medical diagnosis. It is important that the young patient receive immediate medical care as a life threatening condition may be present. Thus, sexual abuse should be assigned priority in triage over all but life threatening emergencies. Upon arrival at the reception or triage desk the child should be directed to a specified area for initial treatment. The initial contact person should be trained to deal with the victim in a sensitive way and should be familiar with the special procedures for victims of sexual assault.

*Patient Coordinator.* A sexual assault patient coordinator should be available on each shift. This coordinator should be familiar with the protocol for the management of sexual abuse cases and with the legal obligations of the hospital. The patient coordinator should be notified as soon as the victim of sexual abuse arrives at the hospital.

The coordinator should act as liaison with the family and friends who accompany the child, counsel them as to the acute needs of the child for sympathetic understanding and caution them against anger or guilt toward the child. The coordinator should determine who, if any, of those accompanying the child will remain with the child during the examination. Consideration should be given to the circumstances and the child's wishes. The police should not be present during the examination and should interview the child only when the coordinator has determined that it is appropriate.

When necessary the coordinator should explain the necessity for the collection of evidence to the victim and/or legal guardian, explain in detail the procedures that will be followed in the collection of evidence and indicate that the examination for the collection of evidence is without charge. Even when there is no plan to prosecute, permission to collect evidence should be sought to prevent its irretrievable loss. The possibility of obtaining positive results is time limited (up to 36 hours post assault). The coordinator should explain consent, the purpose of consent forms and obtain necessary consents—consent for treatment, consent to collect evidence and consent to the release of information. The right to withdraw consent at any time should be explained. The coordinator should explain the confidentiality of the medical record and of the evidence that will be collected.

Because the hospital is obliged to report all sexual abuse cases to the authorities, parents should be advised that a report is being made, prior to reporting. The information should include the victim's name, birthday, sex, address (parents' name and address, phone number), type of assault, date and time of assault, and the extent of injuries. The patient's right not to discuss other details with the police should be explained to the victim by the coordinator.

*Interviewing of child and parents for facts.* This may precede the medical examination or else be initiated as part of the medical examination. In the case of very young children, pertinent facts may be obtained from the parents/guardians or the police. With children already severely emotionally traumatized, it is recommended that the child not be subjected to an immediate interview.

The interviewer should try whenever possible to interview the child alone. The child's version of what happened should be obtained independent of the parents' or caretakers' or suspected offender's version. It is especially important to try to avoid having the child present during the adult's description of what transpired.

In approaching the child, the interviewer should try to convey a relaxed, unhurried attitude. If the interviewer is anxious, uncomfortable, hurried or ill at ease, the child will quickly pick this up and be effected accordingly.

The person interviewing the child should establish a relationship with the child prior to discussing the sexual incident(s). "Zero-ing-in" on the topic of the sexual abuse should be avoided prior to establishing a relationship.

During the interview, it is important to identify and establish the child's level of understanding of human anatomy and what terms he or she uses to identify organs and functions. The interviewer should use the child's own terminology if he or she is too young to use appropriate terminology. Diagrams, pictures, or dolls may be helpful to illustrate or act out what may have occurred.

When eliciting information about the offender, the interviewer should avoid a "who-dunit approach" by not dwelling too heavily on the identity of the offender.

Lastly, the professional interviewing the child and family should be cognizant of his/her personal reactions. That is, he/she should avoid being judgmental about information supplied by the victim, avoid projecting his/her own feelings or perceptions about the situation onto the victim, e.g., the interviewer should not presuppose that the experience was bad or painful for the child—it may have been neutral or even pleasurable; nor should he/she presuppose guilt or anger in the child victim—neither may be present.

The interview has therapeutic aspects. The child should be allowed to talk, bearing in mind that family members may discourage children from verbalizing their reactions. Drawing pictures may also assist a young child to express his/her reactions. Attention should be given to parents' feelings and of the "victim." The parents' aid should be enlisted in supporting the child to express and "work through" reactions to the incident at home. Finally, hospital staff should be prepared to give reassurance to both parents and child.

The more frequent concerns include:

—possible physical damage to the child

—feelings of shame or guilt experienced by the child and/or parents

—potential long term impact on child's physical, emotional, social development (e.g., pregnancy fantasies, sexual preference difficulties.)

## IV. *MEDICAL EVALUATION*

The needs of the child presented to the physician as a victim of sexual abuse are complex and not well defined. A sympathetic understanding physician who delivers thoughtful and sensitive services can avoid unnecessary emotional trauma and help to guarantee a better long term result for the victim. Crisis intervention begins with the early contacts the patient has with hospital personnel. In general:

*Keep an Open Mind.* Recognition of sexual molestation in a child is entirely dependent on the individual's inherent willingness to entertain the possibility that the condition may exist.

*Keep Cool.* Sexual molestation of children is such an emotion-laden topic for most people that objectivity requires much effort and self-discipline. Nevertheless, it is almost impossible to protect or help the child victim in the absence of a calm and professional approach.

*Keep Awake* to the fact that situations of child sexual assault are the most volatile and potentially dangerous of all social problems from the usual perspective of the family and community. Even as you are remaining calm and objective, remember the potential for violent reactions on the part of other participants.

The management of every abused child must be individualized. The child's age, degree of comprehension of the abusive act, discomfort from the act, trauma from the interview or examination are significant factors which may determine the impact of the event on the child. The emotional stability of the child depends to a great extent on the parents. Your interactions with them can establish trust, understanding and permit appropriate follow-up services. (Sgroi, 1975)

The medical evaluation should be performed in a private area by a physician experienced in the treatment of sexual abuse. The patient may be accompanied by a sympathetic staff member, parent, family member or a friend who can offer emotional support. The medical history and examination should be performed in the usual manner with special attention to specific items appropriate to the proper evaluation of sexual trauma and the proper collection of required data and specimens. Full explanation of every step in the examination is necessary, especially an explanation of all procedures. (Specimen collection outlined in SFGH protocol sections IV and V.)

The possibility of life threatening injuries in juveniles should be recognized. Examination should rule out possible penetration of the peritoneal cavity.

### *Admission*

If the initial treating physician feels that there are significant physical injuries or that there may be imminent danger of further abuse, the child should be admitted to the hospital. A police hold may be required if the parent or legal guardian objects. This is not an automatic procedure on child abuse cases. Admission should also be considered if the child is severely emotionally traumatized. In this instance, the examination may be postponed until the child's condition improves sufficiently.

### *Treatment*

A treatment plan should be developed in keeping with the possible problems associated with sexual assault. Consider the need for prophylaxis against gonorrhea, syphillis, use of tetanus toxoid, Kwell, anti-pregnancy options. Specific suggestions are outlined in the protocol. (SFGH VI, VII, VIII)

*Follow-Up*

A follow-up plan is necessary. The circumstances in each case determine what should be included. The plan may include:

1. Appointment for GC culture (4 days if not treated, 7-10 days if treated)
2. Appointment for VDRL in 8 weeks
3. Appointment for other indicated medical services, e.g., x-rays, suture removal, wound check, etc.
4. Appointment for social, psychiatric and community services, as indicated.

The Patient Coordinator should be responsible for these appointments. The Patient Coordinator should contact the victim two to three days after the incident to ascertain whether further support is needed.

The Protocol followed at San Francisco General Hospital is appended.

## REFERENCES

Bay Area Hospital Conference on Sexual Assault. *Medical Protocol for Victims of Sexual Assault*, 1976.

Sgroi, S. M. *Child Sexual Assault: Some Guidelines For Investigation and Assessment*. Connecticut Child Abuse and Neglect Demonstration Center.

Sgroi, S. M. *Sexual Molestation of Children: The Last Frontier in Child Abuse. Children Today*, Vol. 4, May-June, 1975.

## MANAGEMENT OF SEXUALLY ABUSED CHILDREN
## San Francisco General Hospital Examination Protocol

### I. *STAFF*

Services are available to victims of sexual abuse (0-17 years) and include medical evaluation, treatment, evidence collection, crisis intervention and follow-up counseling. Children presenting to SFGH are evaluated by a pediatric resident who is responsible to the Chief Resident and to the Senior Resident. Either the Chief Resident or Senior Resident is consulted on every case, but may not actually perform the examination. Staff nurses assist in examination, treatment, and collection of evidence.

Crisis intervention and follow-up counseling services are provided on a round-the-clock basis by Paula Navin-Burnett, a registered nurse experienced in working with children who have been sexually abused. She is also responsible for follow-up counseling for both the child and family members, under the supervision of Martin E. Glasser, M.D., child psychiatrist, Children's Health Center. All cases of sexual abuse are reviewed by Delmer Pascoe, M.D., Clinic Director.

### II. *PREPARATION OF PATIENT FOR EXAMINATION*

Bring child and parents/guardian to the Clinic exam room. Explain the procedures to the child and parents/guardian and obtain *informed consent* for examination, treatment, and release of evidence. Beware of performing an examination solely for the reassurance of parents. Inquire into the source of parental anxiety and concern.

Determine who, if anyone, should remain with the child during the exam, and direct others to wait in an appropriate area. Assist the patient to disrobe (on a white sheet if debris is present on clothing or hair) and take vital signs.

### III. *EXAMINATION*

The physician will obtain an initial history and perform a general physical examination. Based on the history of the assault, the genital examination may be limited to visual inspection. The extent of the examination will be determined by the physician. Several factors should be kept in mind:

A. If the child was assaulted many days or weeks before presenting to CHC, specimen collection this length of time may not yield sperm or semen. An examination for medical purposes would certainly be indicated.

B. If the history reveals loss of consciousness, drug and/or alcohol ingestion, then specimens should be obtained from all sources (Female: oral, anal, vaginal; Male: oral, anal).

C. If, on visual inspection of the perineum of a female child, the hymen is intact, the introitus is atraumatic, and there is no evidence of genital trauma, a speculum exam may be deferred. However, a cotton-tipped applicator may be passed through the hymeneal ring to obtain forensic specimens and a culture for gonorrhea.

D. If forced sodomy is suspected in a male or female child and visual inspection reveals absence of blood about the anus, no tears, fistulas, or other anal trauma, and if the rectal exam (digital) is negative and the stool is guiac negative then anoscopy may be deferred. Specimens may be obtained with a cotton-tipped applicator both for evidentiary purposes and for GC culture.

E. If the child was forced to perform fellatio on the assailant, specimens should be obtained from behind the upper and lower second molars and under the tongue. A GC culture of the pharynx should also be obtained.

## IV. *SPECIMEN COLLECTION*

A. Vaginal

1. Obtain specimen from posterior fornix with a cotton tipped applicator, smear on a slide, cover with a glass cover slip and examine under high dry power *immediately* for motile sperm. Label slide and preserve.
2. Obtain specimens as above, smear on two glass slides, then insert applicator into a test tube containing 1 cc of normal saline solution. Allow slides to air dry. Seal test tube. Label slides and test tube, and fill out lab slip ("presence of sperm"). Slide mailers are available for slides.
3. Obtain specimen for acid phosphatase as above, insert applicator into a dry test tube, seal and label. Fill out lab slip ("acid phosphatase").
4. ABO/semen typing is not currently available, but is collected in the same manner as acid phosphatase.

B. Oral

Collect specimen with cotton tipped applicator, smear on two glass slides, then immerse applicator into test tube containing 1 cc of normal saline. Allow slides to air dry and seal test tube. Label slides and test tube, and fill out lab slip ("presence of sperm").

C. Rectal

Collect specimens as above in Section IV-B.

## V. *PRESENCE OF SEMEN*

If semen is present on the pubic hairs, labia, or other body surfaces, it will fluoresce a characteristic dark green under Wood's lamp exam. The sample is obtained with a dry cotton tipped applicator and then is placed in a dry test tube. Seal, label and fill out lab slip ("acid phosphatase"). Pubic hairs may be clipped, placed in an envelope, and sealed. Label an envelope and fill out lab slip ("acid phosphatase").

## VI. *SEROLOGY AND CULTURES*

A VDRL should be done on all victims and GC cultures should be obtained as indicated. If the victim is treated with antibiotics, s/he should be instructed to return in 7-10 days to be re-cultured (needless to say, the *same* sites should be cultured on the return visit). If the victim is not treated, s/he should be instructed to return in 4 days. A follow-up VDRL should be obtained in 8 weeks.

## VII. *PREGNANCY PREVENTION*

If penetration has occurred in a post pubertal female victim who does not use any form of contraception and it is likely that conception might result, the physician may elect to dispense DES. If s/he intends to treat the victim with DES, a pregnancy test must be done before administration. A careful history and a bimanual exam should be performed to exclude adnexal masses, an early IUP, or any gynecological abnormalities. The risks involved with DES treatment should be carefully explained and written consent obtained. An anti-emetic such as Compazine or Tigan is usually prescribed to counteract the high incidence of nausea and vomiting associated with DES therapy.

If there are any questions about the history, physical findings, or the administration of DES, the Senior Resident, Chief Resident, or an OB-GYN resident should be consulted by the examining physician.

## VIII. *VENEREAL DISEASE PROPHYLAXIS*

In most cases the physician will elect to administer procaine penicillin and probeniced (Benemid) because of its effectiveness against both gonorrhea and incubating syphillis. If the victim would be emotionally traumatized by injections, Ampicillin and Benemid may be given orally. If the victim is allergic to penicillin, Spectinomycin is the best alternative drug, but must be given IM. If an oral preparation is preferred, Tetracycline is usually prescribed. If the physician chooses to prescribe Tetracycline for a post pubertal female (who may be sexually active), a pregnancy test should be done prior to administration.

## IX. *REPORTING*

Penal Code section 11161.5 requires that a report of suspected cases of child abuse, neglect, and sexual molestation be made to both police and juvenile probation authorities, or alternately either to the county welfare or to the county health department, within 36 hours. The current law requires mandatory telephone and written reports.

Suggested procedure:

The police should be called as soon as possible in the following cases:

A. The incident is recent and parent/legal guardian indicates that they wish to make an official complaint but they have not yet notified the police themselves.

B. The child has suffered physical injury.

C. A "police hold" is necessary to hospitalize the child. A "police hold" is required if the child is, in the physician's judgment, at imminent risk of further abuse or harm or in-patient medical care is required and parents refuse hospitalization. This is not an automatic procedure in sexual abuse cases.

In all other instances of suspected molestation, Children's Emergency Services should be notified.

In all instances, copies of written reports "Report of Suspected Molestation" should be sent to both police and Children's Emergency Services. One copy should be retained by hospital for their own records.

Copies of written reports of physical findings and specimen collection should be given to the reporting police officer or sent to Sex Crimes Detail. One copy should be retained by the hospital for records.

### Procedures for Obtaining Specimens

*Clothing:* Patient should disrobe on a white sheet, which will catch falling debris, hair, leaves, etc. Stained and/or torn clothing should be placed in a paper bag, sealed, and labeled. Give to police officer or store for six months, preserving chain of custody.

*Fingernail scrapings:* If history indicates any attempt on the part of the patient to scratch assailant, fight back, etc., fingernails may contain valuable material. Using a wooden applicator stick or fingernail clipper, scrape the underside of all nails (or clip nails) on one hand and deposit into specimen vial. Do the same with the other hand. Place in second vial. Keep separate "left" and "right," label as such. Give to police officer or store for six months, preserving chain of custody.

*Pubic hair (or other hair):* Observe sheet on the floor and throughout the exam carefully inspect body and clothing for foreign hairs. Retrieve all specimens and deposit in appropriately labeled envelope. Comb pubic and scalp hairs and collect in separate envelopes, if deemed useful. Label and note source. If necessary, hairs may be *plucked* as a standard at a later time to establish a positive identification standard. Should victim desire, standards may be obtained at this time (by *plucking, not* cutting).

*Pubic or Scalp Hair Standards:* (optional at time of exam) *Pluck,* do not cut, 3 hairs from right side of patient's pubis and 3 hairs from left side, label "left" and "right" and deposit in separate envelopes. Do same with 6 scalp hairs, 3 from right, 3 from left. Give all such specimens to police officer or store for six months.

*Wood's Lamp:* If body areas are found containing possible remnants of semen, scan with Wood's Lamp. Semen will fluoresce a characteristic dark green. If semen is present on pubic hair, cut hairs, label and preserve.

*Sperm motility:* Using Q-tip, remove any suspicious collection of material from vaginal vault. If no such suspicious area is seen, posterior fornix is routinely sampled. Place drop of material on slide, cover with coverslip, examine *immediately* under high dry power for motile spermatozoa. State presence or absence of motile sperm.

*Sperm identification:* Swab all suspicious areas with separate applicators (mouth, anus, labia, vagina, cervix, etc.). Smear each swab onto two slides, air drying them both. Preserve the swab in a 1 cc. normal saline. Save slides and wash, preserve chain of custody, and send to appropriate lab for analysis.

Note: THIS TEST IS *NOT* REPLACED BY A POSITIVE MOTILITY TEST (as defense attorney may in court demand perusal of permanent specimen by pathologist of his choice).

*Acid Phosphatase:* (for presence of semen; should be done if sperm are not seen on vaginal smear) Specimens should be collected with Q-tip from any suspicious area (i.e., oral, rectal, or vaginal as indicated). Saturate a cotton-tipped applicator in any suspicious pool, air dry, and place applicator in tube, cover, label, and preserve chain of custody.

*ABO/Semen typing:* Typing is possible on vaginal swab specimens, but better typing results can often be obtained from semen traces uncontaminated by the patient's own secretions, e.g., semen traces on skin, hair, or clothing. It is therefore important that the examiner look for semen traces in or on all these places. Obtain specimen from suspicious area with swab, air dry, place in tube, cover, label, and preserve chain of custody.

# PROCEDURAL GUIDE
# SEXUAL ABUSE EXAMINATION

<72°
Consent for Evidence Collection
Evidence Collection Refused

>72°
Defer Evidence Collection
Proceed with Medical Exam
as Indicated Below

**Oral-Genital Contact**

1. Collect forensic specimens
   a. 2 fixed slides
   b. wet mount—examine immediately for motile sperm
   c. acid phosphatase
   d. I saline wash
2. Pharyngeal culture for gc
3. Serology
4. gc prophylaxis

**Vaginal Penetration**

1. Collect forensic specimens
   a. 2 fixed slides
   b. wet mount—examine immediately for motile sperm
   c. acid phosphatase
   d. saline wash
2. Wood's lamp exam:
   +collect for acid phosphatase
   —proceed to #3
3. gc culture
4. gc prophylaxis
5. Serology
6. Consider DES
   1. pregnancy test
   2. bimanual pelvic exam
   3. anti-emetic

**Intact Hymen**

1. gc culture
2. Serology
3. gc prophylaxis
4. urine analysis (midstream) for occult blood

**Anal Penetration**

1. Collect forensic specimens.
   a. 2 fixed slides
   b. wet mount—examine immediately for motile sperm
   c. acid phosphatase
   d. saline wash
2. Digital exam and stool guiac:
   +consider anoscopy
   —proceed to #3
3. gc culture
4. Serology
5. gc prophylaxis

**Vaginal Discharge**

1. Urine analysis
2. gc culture
3. wet mount
   +trichomonas flagyl
   —proceed to # 4
4. KOH prep
   +Candida mycostatin
   —proceed to #5
5. gram stain
   +bacteria triple sulfa preparations
   +gc begin treatment (gram stains may be relied on to diagnose gc in prepubertal females Single dose Ampicillin/Probenecid is effective)
6. Serology

## SAN FRANCISCO GENERAL HOSPITAL—CHILDREN'S HEALTH CENTER

### Physician's Sexual Assault Checklist

Name ________ Sex ____ Birthdate ________
Address ________ Telephone ________
Name of parent/guardian ________
Address ________
Brought in by ________ Address ________ Telephone ________
Date and time of assault ________ Date and time of exam ________
Police called by ________ Time ________ Officer ________ Star # ________
Children's Emergency Services Notified ________ Date & Time ________ By ________
CES Worker ________

*MEDICAL HISTORY.* Include past medical/surgical history, current medical problems, current medications, any known allergies. ________

*PHYSICAL EXAMINATION.* T. ________ P. ________ R. ________ B/P ________ Wt ________

General appearance (include condition of clothing) ________

Emotional status (your observations; do not make judgements) ________

General physical examination ________

Body surface (locate and describe injuries; obtain from patient possible source and nature of injury; note on diagram)

| | Findings | History |
|---|---|---|
| Mouth | | |
| Head/neck | | |
| Back | | |
| Chest/breast | | |
| Abdomen | | |
| Upper extremities | | |
| Lower extremities | | |

Fingernails: (note if broken, collect scrapings if relevent) ________

External genitalia: (describe appearance, presence or absence of pubertal changes, introitus) ________

If penetration or ejaculation occurred, or consciousness lost, complete pertinent history and physical examination below:

## *HISTORY*

Menstrual: LMP__________ LNMP__________ Cycle__________
Contraception: Yes__________ No__________ Type__________
During assault: What acts occurred? coitus________ sodomy________ fellatio________ cunnilingus________
(to victim) (specify)__________________
Did assailant ejaculate? Yes___ No___ Unk___
Did loss of consciousness occur?* Yes___ No___ Unk___
*if yes or unknown, obtain specimens from all possible orifices
Foreign object(s) used? (specify)__________________
Since assault has patient rinsed mouth, brushed teeth, consumed food or liquid?__________
douched___ bathed___ defecated___ urinated___

## *EXAMINATION*

Pelvic examination, as indicated.

Vulva__________ __________
Vaginal introitus__________ __________
Vaginal canal__________ __________
Cervix__________ __________
Uterus and Adnexae__________ __________
Hymen__________ __________
Perineum__________ __________ __________
Anus__________ __________ __________
Male Genitalia__________
__________________

## *LABORATORY AND EVIDENTIARY MATERIAL* (items are for evidentiary purposes only)

See: Procedures for Obtaining Specimens

—Clothing: list__________________
__________________

| | |
|---|---|
| —Pubic hair | Purpose: Foreign?________ Fluorescence?________ |
| —Scalp hair standards | Collected? Yes___ No___ |
| —Fingernail scrapings, cuttings | Collected? Scrapings Yes___ No___<br>Cuttings Yes___ No___ |
| —Wood's lamp: fluorescence found? | Area (specify)__________ Yes___ No___<br>Area (specify)__________ Yes___ No___ |
| —Sperm motility: Spermatozoa found | Yes___ No___ |
| Motile sperm found | Yes___ No___ |

| Indicate source of Specimens | Mouth | Anus | Labia | Vagina-Cervix |
|---|---|---|---|---|
| —Specimens for sperm identification: Air-dried slide | ___ | ___ | ___ | ___ |
| Slide wash | ___ | ___ | ___ | ___ |
| —Acid phosphatase air dried swab | ___ | ___ | ___ | ___ |
| —ABO Semen Typing: (Specify source) | ___ | ___ | ___ | ___ |

| | DONE | NOT DONE | POSITIVE | NEGATIVE |
|---|---|---|---|---|
| Stool Guaiac or rectal swab for blood | ___ | ___ | ___ | ___ |
| Urine for occult blood (if child molestation or ? bladder injury) | ___ | ___ | ___ | ___ |
| VDRL | ___ | ___ | | |
| GC culture (if required by victim) | ___ | ___ | | |
| Pregnancy test: (mandatory if giving DES) | ___ | ___ | ___ | ___ |

Other tests: (specify)__________________

__________________M.D. __________________
Examining Physician Date

cc: Police

******************************

### *RECEIPT OF EVIDENCE*

**Specimens collected by**______________________________ **M.D. on**__________ **at**__________

**to Examining nurse**______________________________ **R.N. on**__________ **at**__________

**to SFPD Officer**______________________________ **Badge #**________ **on**________ **at**________

***ADMISSION.*** If the initial treating physician feels that there are significant physical injuries or that there may be imminent danger of further abuse, the child should be admitted to the hospital. A police "hold" may be required if the parent or legal guardian refuses hospitalization. This is not an automatic procedure on child sex abuse cases. By calling the Police Department or Children's Emergency Service, a "hold" will be placed on the child—this means that it is illegal for anyone to remove the child from the hospital without the court's consent. The police will probably follow-up this hold with a visit to the hospital. They may be in uniform. A police hold is in effect for 72 hours or 3 working days. The "police hold" forms should be available in the hospital.

### *TREATMENT PLAN AND FOLLOW-UP*

Medications for GC prophylaxis:

Procaine Penicillin/Benemid ____________________

Ampicillin/Benemid ____________________

Amoxicillin/Benemid ____________________

DES ____________________

Tetanus Toxoid 0.5 cc. ____________________

Kwell oz. ____________________

Other (specify:____________________) ____________________

MAXIMUM DOSAGES—recommended adult dosage

Procaine PCN G: 100,000 cc/Kg in two injection sites. Maximum does 4.8 million units/Benemid 25 mg/Kg po Maximum 1.0 gm.

Amoxicillin 50 mg/Kg po Maximum 3.5 gm/Benemid 25 mg/Kg po Maximum 1.0 gm.

Spectinomycin 40 mg/Kg 1 M in two injection sites Maximum 2 gm.

Tetracycline: 25 mg/kg po initial dose then 10 mg/kg po qid x 4 days Maximum 1.5 gm. initial dose and 0.5 gm subsequently (total not to exceed 9.5 gm)

Ampicillin: 50 mg/kg po Maximum 3.5 gm/Benemid 25 mg/kg po Maximum 1.0 gm

DES: 25 mg po bid x 5 days (with anti-emetic)

Referrals:

Venereal Disease

GC culture (4 days if not treated, 7-10 days if treated)

Date______________________________ Location______________________________

VDRL (in 2 mos.)

Date______________________________ Location______________________________

Sexually active patients should refrain from intercourse until repeat cultures are obtained.

Pregnancy test______________________________

Pregnancy counselling______________________________

Crisis Intervention Services______________________________

Psychological folltw-up services______________________________

______________________________ M.D. ____________________

Examining Physician Date

______________________________ R.N.

Examining Nurse

# GUIDELINES FOR TREATING SEXUAL COMPLAINTS IN CHILDREN AND ADOLESCENTS

**The following five situations are apt to present in the Pediatric Clinic or the Emergency Room. The appropriate role and responsibilities of pediatric and ob-gyn house staff are outlined below. In those cases which do not fit the situations listed below, the physician should use his clinical judgment to decide what is best for the patient.**

| Type of Alleged Sexual Assault | Complete Evaluation and Rx. by GYN resident in ER (4) | Eval. and Rx. by ped. in Adol. Clinic or ER (5) | GYN consult for forensic pelvic exam (6) | Report to Child Welfare (7) | Stat Psycho-social Evaluation | Psycho-social Follow-up Appointment | Call Rape Counseling Service |
|---|---|---|---|---|---|---|---|
| 1. Rape—over 18 years/ plus under 18 if married or an emancipated minor (1) | X | | All | None | Most, ER psychiatrist | As needed Adult Psych. | Most (11) |
| 2. Rape—17 and under, unless married or emancipated minor (1) | | X | All | None | Most, Adolescent Clinic SW (8) | Most Adolescent Clinic SW (10) | Most (11) |
| 3. Concern by parents regarding recent alleged sexual relations in their teenager, (but no rape or desire to prosecute). | | X | None | None | Some, Adolescent Clinic SW (8) | As needed, Adolescent Clinic SW (10) | None |
| 4. Incest (2) (family-related) | | X | All with intercourse within 48 hours | All | All, CPT-SW (9) | Child Welfare SW | None |
| 5. Child molestation (3) (both family-related and non-family related) | | X | None | All | All, CPT-SW (9) | Child Welfare SW | None |

## SAN FRANCISCO GENERAL HOSPITAL

### PEDIATRIC DEPARTMENT
### FOLLOW-UP INFORMATION SHEET

Name________________________________ ____________

***EXAMINATION***

Your examination was performed on________________to:

1. determine if any injuries were present which required treatment,
2. do a number of lab tests which can provide medical and legal information. This information could be used in court as evidence if you decide to sign a complaint against the assailant.

***LABORATORY TESTS***

The blood test and cultures taken today need to be repeated to insure that you/your child are/is adequately protected against venereal disease. The culture will be repeated on ________________ at ________________, and the blood test will be repeated in six to eight weeks. This helps insure the best possible care for you/your child.

***MEDICATION***

______ You/your child received medication to insure protection against venereal disease (syphilis and gonorrhea)

______ You/your child received medication for pregnancy prevention.

______ You/your child need no medication at this time________________________________________________.

***FOLLOW-UP VISITS***

The counselor you had contact with today is ______________________. Please feel free to call him/her if you experience any physical or emotional distress or need to discuss any concerns you may have. Telephone________________________.

Please call for an appointment change or advice if you/your child show:

1. Signs of infection: fever, pain, sores, vaginal discharge.
2. Urinary symptoms: blood in the urine, painful, difficult or frequent urination.
3. Unusual vaginal bleeding or spotting.
4. If your menstrual period does not occur when expected or within a week after completing the medicine given to prevent pregnancy.
5. Difficulty eating, abdominal pain, nausea, or vomiting.
6. Difficulty sleeping.
7. Bedwetting, nightmares, unusual fears.
8. Rectal bleeding.

PLEASE RETURN TO____________________________clinic on______________at______________ for the first follow-up visit.

SPECIAL INSTRUCTIONS______________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

## SAN FRANCISCO GENERAL HOSPITAL
## PEDIATRIC DEPARTMENT

### Report of Suspected Molestation

**Child's name:**________________________________________**Date of Birth**________ **Sex:**________
**Child's address:**________________________________________________________________
**Parents' name:**________________________________________ **Phone:**____________________
**Type of molest:**____________________________________________
**Date of molest:**____________________________________________
**Time of molest:**____________________________________________
**Extent of injuries (if any):**__________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
**Report submitted by:**____________________________________________________**M.D.**
**Date:**________________________________________________________________

**Original to hospital files**
**cc: Outreach-Court Protective Services**
**S.F. Police Department**

## SAN FRANCISCO GENERAL HOSPITAL PEDIATRIC DEPARTMENT

## CHILD/ADOLESCENT SEXUAL ASSAULT INTERVIEW

**Date**__________ **Name**______________________________ **AGE**__________ **Sex**__________
**B. #**__________ **Address**______________________________________ **Phone**__________
**Parent/Guardian**______________________________ **Address**______________________
**Examined on**______________ **By**______________________________, **M.D. Specimens**__________
**CES Notified on**______________ **By**______________________________ **CES Worker**__________
**HISTORY:**______________________________________________________________
______________________________________________________________________
**INTERVIEW:**____________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
**IMPRESSION:**___________________________________________________________
______________________________________________________________________
______________________________________________________________________
**PLAN:**________________________________________________________________
______________________________________________________________________

**FOLLOW UP: 24 hrs., 72 hr., one week**
**Date**________ **Time**________ **By**________________ **Result**______________________
______________________________________________________________________
**Date**________ **Time**________ **By**________________ **Result**______________________
______________________________________________________________________
**Date**________ **Time**________ **By**________________ **Result**______________________
______________________________________________________________________

**CES FOLLOW UP:**
**Date**______ **Time**______ **CES Worker**____________________ **Contacted by**______________
**Result**_______________________________________________________________
______________________________________________________________________
______________________________________________________________________
**REFERRALS:**___________________________________________________________
______________________________________________________________________
______________________________________________________________________
**DISPOSITION:**__________________________________________________________
______________________________________________________________________
**COMMENTS/RECOMMENDATIONS:**______________________________________________
______________________________________________________________________
______________________________________________________________________

## *CONSENT FOR TREATMENT AND/OR COLLECTION OF EVIDENCE*

DATE:______________HOUR:____________

1. I hereby request, authorize and direct __________________________, M.D. and associates to perform the following examination(s) (strike those which do not apply):

(a) General physical and pelvic examination________________________________

(b) Prophylactic treatment for venereal disease______________________________

(c) Collection of materials, specimens and/or photographs to be used as legal evidence of sexual assault__________

(d) Further lab tests deemed appropriate by examination__________________________
__________________________________________________________________

2. The nature and purpose of the examination(s), lab tests and/or treatment(s) have been fully explained to me by Dr. _____________________ and it has been explained to me and I understand that these drugs are not totally effective in the prevention of venereal disease.

3. I understand that I am to consult my private physician or contact a Clinic at designated times for tests to determine whether venereal disease has been contracted and whether pregnancy has developed.

4. I have read the above request and I understand fully the contents of each paragraph.

____________________________________
Patient's Signature

____________________________________
Witness

____________________________________
Witness

(If patient is a minor or is unable to sign, the following must be completed.)

_____Patient is a minor

_____Patient is unable to sign because:
____________________________________________
____________________________________________

____________________________________
Father

____________________________________
Mother

____________________________________
Guardian

____________________________________
Other person/relationship

---

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize__________________________________________to supply copies of ALL medical reports including
(Hospital Name)
any laboratory reports, immediately upon completion, to the Police Dept. and the Office of the District Attorney having jurisdiction.

Person
Examined______________________________________
Address_______________________________________
Parent or
Guardian______________________________________
Address_______________________________________

Date___________________________________

Witness__________________________________

## *DIETHYLSTILBESTROL (DES) INFORMATION*

DES or the "morning-after pill" is administered in a 5-day series within 72 hours of intercourse. It is about 90%-100% effective. Because it can cause severe nausea and vomiting an anti-nauseant should be taken with it.

Why DES is not recommended:

1. Between 1945 and 1970 millions of pregnant women in the U.S. were prescribed DES as an "anti-miscarriage" drug. As a result 220 daughters from these pregnancies developed an unusual type of vaginal cancer (clear-cell adeno-carcinoma) at puberty. The woman who takes DES after being raped may already be pregnant. DES could affect the child she is carrying (i.e., vaginal cancer in a female child or testicular abnormalities in a male child.)
2. DES when tested on laboratory animals caused breast, uterine, and cervical cancer. Probably a woman who takes DES once will not develop cancer. However, there is a danger that it may activate latent cancers that are not detectible by current medical procedures.
3. Chances of being pregnant are between 4% and 10%.

DES is contra-indicated for women who:

1. Cannot take birth control pills due to estrogen reactions.
2. Have sickle-cell anemia.
3. Have a history of breast, uterine or cervical cancer.
4. Are diabetic (high blood sugar).
5. Are hypoglycemic (low blood sugar).
6. Have hypertension (high blood pressure).
7. Have family histories of blood clotting disorders.
8. Have own history of blood clotting including patient history of thrombophlebitis.
9. Are menopausal. DES may bring on a period or other reactions.
10. Are pregnant.
11. Have history of liver disease.
12. Are daughters of women who were given DES during their pregnancy.

If the victim decides to take DES:

1. She should receive a urine HCG pregnancy test that will determine if she is 6 weeks or more pregnant. If the victim is pregnant, DES should not be given.
2. Because of the possibility of propagating cancer, she must receive a thorough breast and vaginal examination to check for any signs of cancer.
3. She should be given an anti-nauseant.
4. If she becomes pregnant due to failure of the drug, an abortion is strongly recommended.
5. She should get checks for vaginal cancer, pelvic exams and pap smears every six months and do breast self-exams monthly for the rest of her life.

For copies of "What the Rape Victim Should Know About the Morning-After Pill" by Kay Weiss, write to:

Advocates for Medical Information
2815 Stanton
Houston, Texas 77025

## *CONSENT FOR TREATMENT WITH DIETHYLSTILBESTROL*

**Patient's Name**____________________ **Date**____________________

**Address**____________________ ____________________

**I have read and understand the DES Information Sheet given to me by the hospital and received a full explanation of the treatment from the attending physician.**

____________________

**Patient's Signature**

____________________

**Witness**

**If patient is a minor or unable to sign, a parent or guardian may sign.**

____________________

**Relationship to Patient**

____________________

**Name (Signature)**

- - - - - - - - - - - - - - - - - - - - - - - - -

## *CONSENT FOR BLOOD DRUG ALCOHOL CONTENT*

**I the undersigned do hereby consent to the withdrawal of a blood sample to be checked for alcohol and/or drug content.**

____________________

**Date**

____________________

**Patient's Signature**

____________________

**Witness Signature**

**If patient is a minor or unable to sign, a parent or guardian may sign.**

____________________

**Relationship to Patient**

____________________

**Name (Signature)**

## *PATIENT INFORMATION*

***YOU HAVE THE RIGHT TO:***

1. Immediate medical care;
2. A complete physical examination;
3. Treatment for the prevention of venereal disease and pregnancy;
4. A full explanation of all treatment given and the available alternatives;
5. Read your medical report and request additions and corrections;
6. Counselling services;
7. Referrals for additional treatment and services;
8. Refuse to make a police report or release evidence.

***ABOUT THE EXAMINATION:***

The doctor will examine you for injuries and general trauma. He/she will check you for injuries in any areas affected by the assault and will talk with you about VD and pregnancy prevention. If you choose to do so, you may receive treatment from the hospital. They will also provide you with alternate methods of treatment.

If you have decided to have the hospital collect evidence, certain tests will be necessary. The appearance of your clothing and any sign of force or injury to your body are legal evidence for a possible criminal prosecution. Foreign matter on your body or on your clothing may also provide evidence. This is why the doctor should examine you carefully and completely, and collect specimens to send to the police crime laboratory.

The tests for evidence may include pubic hair collection, possible fingernail scrapings and possible photographs of bruises. The doctor will also collect a swab from the vagina or other areas for sperm. If there are no sperm (as in a man who has had a vasectomy) the doctor will take a swab and test for semen.

***FORMS:***

You will be asked to sign many consent forms. Take your time to read them and/or ask questions about them. The doctor, nurse, or counselor will be able to explain them to you and discuss them with you.

***WHEN YOU LEAVE:***

You will be given a follow-up sheet. It will have information about follow-up tests and explain some of the tests that were done.

# Medical and Counseling Protocol For The Treatment of Sexually Abused Minors

**Kauikeolani Children's Hospital**
**Sex Abuse Treatment Center**
**Honolulu, Hawaii**
Prepared by:
Paula Chun, M.S.W., Director, Sex Abuse Treatment Center
Gail Breaky, R.N., M.P.H., Family Stress Center
Gwen Costello, R.N., M.P.H., Family Stress Center
George Starbuck, M.D., Medical Director, Child Protective Services
Eberhart Mann, M.D., Medical Consultant, Sex Abuse Treatment Center
Deborah Gaynor, M.S.W., Social Worker, Sex Abuse Treatment Center

## RECEIVING AND HANDLING CALLS FOR KAUIKEOLANI CHILDREN'S CHILD CRISIS CENTER

The counselor/coordinator will be available at Children's Hospital from 8:00 a.m. to 4:30 p.m. to respond as a crisis worker. She can be reached at ext. 164 or via beeper (533-2200). After hours, weekends and on holidays, a trained crisis worker from the Suicide and Crisis Center can be reached at 533-2200 to respond to calls.
Calls will come from victims, victim's family, persons in the community, police, Suicide and Crisis switchboard and CPSC.
Situations may involve the following:

A. *Suicide Crisis "Sex Abuse" hotline*

1. When a call comes in via the Suicide-Crisis hotline, the patient (pt.) will be connected with a crisis worker (cw) or KCH counselor who will encourage the pt. to come in to the hospital for emergency treatment.

   If it appears to be an acute emergency situation and the pt. is injured, arrangements should be made with the pt., pt's. family or friends, cw or police to have the pt. picked up by the City and County ambulance and transported to the hospital. The cw should coordinate arrangements.

3. The cw will either offer to pick up the pt. and bring her/him to the hospital or will meet her/him at the hospital.

   After talking to the pt., the cw-counselor will then call the Emergency Room (ER) charge nurse at the hospital and notify her of the pt.'s approximate arrival time.

   The E.R. nurse will notify the following units:
   a. On call physician
   b. Pathology Department
   c. Admissions Clerk

B. *Hospital*

1. Walk-In
   a. If a pt. and/or family arrives at the hospital without prior notification of police, hospital staff and/or Suicide Crisis hotline, they should be taken to a private area and the E.R. charge nurse should be notified immediately by the admitting clerk.
   b. The E.R. charge nurse should then notify the following units:
      a. On call physician
      b. Pathology Department
      c. Hotline

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c. After receiving the call from the E.R. charge nurse, the hotline will then notify the cw of the pt.'s arrival.

2. Call-In

a. When a pt. phones the hospital to report a case of sex abuse the call will be connected to the E.R. charge nurse who will encourage the pt. to come to the hospital for emergency treatment. (See Role of Nurse)

b. The E.R. charge nurse will notify the following units of pt.'s approximate arrival time:

a. Physician
b. Pathology Department
c. Hotline

### II. *Arrival*

A. With Crisis Worker

1. Upon arrival at the hospital, the pt. will go to a private area with the cw.

2. The cw will provide the pt. with emotional support and obtain signatures required in the consent section. (Refer to protocol for signing consents for minor, admitting clerk's role and forms section of protocol for assistance.)

3. The registration form will be completed by the cw as time permits and after the emotional needs of the pt. have been taken care of.

B. Without Crisis Worker

1. If the pt. appears upset or is crying, the admitting clerk should take the pt. to the E.R. and inform her/him that a hospital staff will be arriving to provide emotional support and to accompany her/him throughout the proceedings.

2. The hospital staff staying with the pt. in the E.R. should wait with the pt. until the cw arrives. The staff should try to make the pt. feel as comfortable as possible.

3. When the cw arrives, she will provide the pt. with emotional support. The cw will also obtain signatures outlined in the Consents Section.

4. If a pt. appears relatively calm, the admitting clerk can begin assisting the pt. to fill out the registration form before the cw arrives.

### III. *Initial Screening*

A. After the cw or admitting clerk has obtained the signatures for consents, the nurse will proceed with an initial physical assessment of the pt. in order to determine whether the pt. should be:

1. Seen by a E.R. Physician or resident on call for injuries and shock. (Emergency treatment)
2. Treated as an (emergency) outpatient at Children's Hospital.
3. Hospitalized at Children's.

B. The E.R. nurse will consult with the on call physician on any decision to hospitalize or call in a specialist. The nurse should report her assessment, injuries, the need for a specialist, etc., to the on call physician. He may request that the nurse call the specialist or house officer before his arrival.

C. The nurse will outline and explain all procedures including history, physical examinations, tests and possible medications that will be administered.

D. For all pts. the E.R. nurse will obtain vital signs and other assessments as appropriate and record the results in the nurses' section of the examination form.

### IV. *Preparation for the Medico-Legal Examination*

A. Locked Box

1. After receiving a call, the E.R. nurse will arrange to pick up the locked box from the laboratory technician and sign the receipt for it.

2. The nurse who signs out for the locked box is responsible for returning it to the laboratory. If, due to a change of duty shifts, the nurse who signed out for locked box cannot return it to the laboratory, the E.R. charge nurse should designate a second nurse from the next shift to co-sign for the locked box and she will become responsible for returning the box.

B. Preparation of Patient

1. Immediately prior to the medico-legal examination, the nurse will assist the pt. to undress and drape the pt.

2. The nurse will chaperone the examination and assist the physician during the examination.

### V. *Medico-Legal Examination* (see physician's role for details)

In all recording it should be remembered that "rape" and "sexual assault" are legal terms and not medical diagnosis; i.e., use the diagnosis "history of alleged rape or sexual assault."

The following procedures should be carried out by the physician:

- A. Respond promptly to provide overall case management.
- B. Review case with E.R. nurse, cw, police and obtain directed history from pt.
- C. If it has not been established that the case is family or not-family oriented it should be done by the physician with the help of the cw and/or police. If it is a family-oriented situation the physician or physician's designate should have the CPSC Intake Worker notified as soon as possible through the hospital switchboard.
- D. Perform the necessary physical examination, including a pelvic examination when indicated. A female attendant must be present as chaperone. Record findings on the examination form.
- E. Obtain medico-legal specimens for laboratory tests.
- F. Provide treatment and make follow-up arrangements.
- G. Record impressions.

VI. *After the Medico-Legal Examination*

Any immediate needs of the pt. should be taken care of prior to discharge, i.e., clothing, transportation or a place to stay. These arrangements should be made by the cw or CPSC social worker. If the pt. is not going home, the address and telephone number where she will be staying should be noted.

- A. Discuss follow-up medical care with pt. (See physician's role for details)
- B. Consultation and referrals (See physician's role for details)
- C. Locked box and other evidence
  - 1. The responsible nurse should return the locked box to the laboratory.
  - 2. If the pt. is not sure if he/she wants to report to the police, the physician can do a Wood's lamp test on the clothing and send the clothes to the laboratory for additional testing. The results will be documented on the physical exam form and the laboratory report.
  - 3. The counselor/coordinator will arrange for third party reporting if pt. does not want to report to the police.
- D. Handouts to be given pt. by cw:
  - 1. Appointment slip for follow-up medical examination.
  - 2. Brochure and application form for State Criminal Injuries Compensation Commission if appropriate. It should be noted on the cw's report if the brochure and application were given to the pt.
  - 3. If it is a non-family oriented case, give the pt. the name and phone number of the KCH counselor. If it is a family-oriented case and CPSC worker does not meet the pt. at the hospital, tell the pt. a DSSH social worker will be following up.
  - 4. Other handouts as needed.
- E. The cw may remain with the pt. and family during detective questioning if requested to do so.

VII. *Follow-up Services*

- A. Pathology Report
  - 1. The lab technician should report the results of the urine/pregnancy test to the E.R. staff by phone.
  - 2. After the pathologist has tested the medical and legal specimens, the results should be recorded on the pathology form enclosed in the locked box. The presence or absence of sperm should be particularly documented.
  - 3. The report should then be signed by the pathologist and sent to:
    - a. medical records or,
    - b. medical consultant.
  - 4. The medical consultant will send a copy of the final report to the police if consented to by the pt., and retain one copy for his records.
- B. Medical Follow-up (record on medical follow-up form)
  - 1. For all pts.
    - a. In one week or as recommended by physician arrange for:
      - 1. Repeat pregnancy test-serum pregnancy test is necessary.
      - 2. Repeat GC cultures if necessary.
      - 3. Determine need for psychiatric or psychological evaluation. Non-family oriented cases can be referred to the KCH Child Crisis Center social worker.
      - 4. In 6 to 8 weeks: repeat VDRL.
  - 2. Some patients may require:
    - a. Repeat pelvic exam one week to determine pt.'s medical status.
    - b. If pregnancy occurs or is anticipated, follow-up medical treatment may include abortion or a menstrual extraction.
    - c. If VD occurs, administer VD treatment and make a report and referral to the VD clinic for follow-up.

- C. Counseling Follow-up (see counselor's role for details)
  - 1. Initial follow-up call by counselor/coordinator
  - 2. Provide counseling and referral services
  - 3. Facilitate legal support

## *PHYSICIAN'S ROLE*

- I. *Notification*
  - A. When the emergency room nurse is alerted that a pt. is to be brought to the hospital, the physician on call will be notified. Refer to call list posted in emergency room and/or switchboard.
- II. *Preparation for Medico-Legal Examination*
  - A. The physician should respond promptly to provide overall case management as outlined below:
    - 1. Review the nurse's, cw's, and police reports (if available) regarding the case.
    - 2. Inform the pt. of the need to gather medical and legal information. (Although the pt. is not required to report the sexual assault to the police, he/she should be encouraged to do so in order to apprehend the suspect.)
- III. *Medico-Legal Examination*
  - A. Obtain directed medical history. Specifically ask about:
    - 1. Menstrual, contraceptive, coital, and VD history and activity following the assault (change of clothing, bathing, douching, alcohol, drugs, etc.)
    - 2. Complete Sensitive Questions in examination form. The physician must ask the pt. these questions and record the answers. These questions will not be asked again by the police (as agreed upon with the HPD).
    - 3. Prior psychological/behavioral disturbances.
    - 4. Whether the alleged perpetrator was a stranger or family member. Notify CPSC intake worker as soon as possible in family oriented cases.
  - B. Perform the necessary physical examination, include a pelvic examination when possible. A female attendant must be present as chaperone. The time of examination should be written. Record finding on examination form.
    - 1. General examination should include the emotional state and behavior of the pt., her general appearance and that of her clothing. Document areas of obvious trauma by photograph and/or diagram.
    - 2. A detailed examination should be directed to areas involved in the alleged sexual assault, i.e., breast, genital, anal and oral.
    - 3. A complete pelvic examination, especially in the absence of trauma, may be unnecessary or postponed in very young and/or very apprehensive pts. In these cases specimens may be obtained with the use of a sterile pipette or tapered medicine dropper without the use of stirrups and specula.
    - 4. Obtain medico-legal specimens for laboratory tests: (see form in locked box)
      - 1. Ultra-violet lamp (Wood's lamp) will cause semenal fluid to fluoresce (even after vasectomy) and will identify areas on the body or clothing needing specific attention for further examination. Use in darkened room after visual adaptation. Note and record on a diagram.
      - 2. Pregnancy test if indicated (especially if there is some possibility pt may be pregnant). Urine for pregnancy test and sperm examination should be sent immediately to the lab. Report of pregnancy test must be received before the "morning after" pill is prescribed.
      - 3. Culture body orifices for gonorrhea, e.g., throat, endocervix, rectum.
      - 4. Do a vaginal wash with 2 cc. of diluent only.
        - 1. For acid phosphatase, sperm, and ABO antigen determination collect specimens from areas of fluorescence or involvement.
        - 2. Place aspirated material in the container provided and scraped specimen in capped labeled tube, or soak area with gauze (4 x 4) dipped in saline and save for testing.
      - 5. Take Pap smear. Pathologist will document presence or absence of spermatozoa.
      - 6. Baseline VDRL should be obtained as indicated.
      - 7. Obtain further specimens to help identify the offender as requested by police.
        - 1. Comb pubic hair for evidence and place combings in the envelope. Label.
        - 2. Take scrapings from under fingernails and place in another clean envelope. Label.
      - 8. Save original clothing as evidence for police.

D. Treatment

1. The pt. should be calmed and reassured. Sedatives and/or tranquilizers may be prescribed as needed.
2. Treat injuries as indicated. Referrals to or appropriate consultation for other services should be arranged as indicated.
3. Ascertain the wishes of the pt. regarding hormonal pregnancy prevention. Pregnancy prophylaxis should be given if the pt. is menarchal and not pregnant, is using no contraception and is at high risk during the cycle. Written consent for hormone treatment must be obtained by the physician. If hormonal therapy is decided upon, the pt. should be informed that taking estrogens may result in increased risk to the fetus if already pregnant. Obtain informed consent.
   She should be assured that if she misses a menstrual period in spite of therapy, or fails to have withdrawal bleeding to estrogens, menstrual extraction or abortion can be performed. This can be discussed in further detail at follow-up visit.
4. Medications
   1. Diethyl Stilbesterol 25 mg. B.I.D. for 5 days.
   2. Bendectin (2 tablets at H.S. and 1 tablet B.I.D. as needed for nausea and vomiting).
5. V.D. prophylaxis must be provided in all cases of penile or oral contact with the vagina, mouth, or rectum. The options are listed in order of preference.
   1. Probenecid 1.0 gm orally followed with Procaine Penicillin G 4.8 million units I.M. (if not allergic to Penicillin). Divided doses in each buttock (good for GC and syphilis).
   2. Probenecid 1 gm orally + ampicillin 3.5 gms stat orally. (good for GC and syphilis)
   3. *If allergic to Penicillin*, the following oral doses are good for GC and syphilis:
      Tetracycline 1.5 gms stat 0.5 gms QID for 10-14d (do not use Tetracycline in pregnancy)
6. Give Tetanus Toxoid as indicated according to Public Health recommendations.

E. Final Diagnosis

1. Document final diagnosis including:
   a. History of sexual assault
   b. Note lab reports completed
   c. Specific diagnosis of trauma: contusions, lacerations, etc.
   d. Other pertinent medical diagnosis.

IV. *After the Medico-Legal Examination*

Any immediate needs of the pt. should be taken care of prior to discharge, i.e., clothing, transportation or a place to stay. These arrangements should be made by the cw or CPSC worker. If the pt. is not going home, note in the record the address and telephone number where she/he will be staying. Cleansing douche may be offered.

A. Discuss follow-up medical care with pt.

1. The pt. should be impressed with the fact that a follow-up visit to his/her physician or the OPD is absolutely necessary in order to check on pregnancy and venereal disease.
   a. Explain to pt. the need for a repeat pregnancy test in 2 to 6 weeks, if her next menstrual period is delayed or abnormal in any way.
   b. Explain that smears and cultures for GC will be repeated at her follow-up visit if indicated.
   c. A VDRL will be repeated in 8 weeks if indicated.
2. Make an appointment in 7-10 days at the OPD Adolescent Clinic with Dr. Mann.
3. If pt. plans to have follow-up care elsewhere, have pt. sign a release of information form.
4. Tell pt. to call the Child Crisis social worker by phone or return to the hospital at any time to discuss any problem, emotional or medical that may arise.
5. Record pt.'s plans for follow-up on exam form.

B. Consultation and Referrals

1. Request further consultation from pediatrician, surgeon, psychiatrist, etc., as needed.
2. Follow-up psychiatric or psychological care of a sexually abused pt. is most important. The incident may result in an emotional crisis for the pt. which may extend to the immediate family, etc. (husband, boyfriend, friends)
   a. The physician should discuss this aspect of his/her follow-up with care and understanding. Make a referral for counseling at KCH and encourage the pt. to call about anything on his/her mind.

## *NURSE'S ROLE*

The major role of the nurse is to assure respect for the privacy and sensitivity of the patient and/or family, to provide emotional/psychological support, and to facilitate the physician's treatment procedures. The on-duty nurse making the initial contact should follow the case until discharged or until turned over to the cw.

Cases may be referred by the Suicide-Crisis Center hotline, police, CPSC or by self-referrals. When a case is referred, the nurse is responsible for notification of the following:

—physician on call  
—pathology  
—admitting (unless call comes through admitting)  
—crisis line (533-2200) if call did not come through cw (Exception to this would be if CPSC makes the referral and wishes to follow-up the case at the hospital)

If a pt. phones the hospital to report a case of sex abuse, the call will be connected to the E.R. nurse who will encourage the pt. to come to the hospital for emergency treatment. This is a crisis situation and the nurse will have to help the pt. and/or family make quick decisions and to assess her physical and emotional needs. Elicit basic information such as name, age, phone number and approximate time of arrival. Advise her not to wash, douche or change clothes. Advise him/her to bring a change of clothes. If the pt. does not have transportation to the hospital, call the hotline to arrange for a cw to provide transportation. In cases of injury the E.R. nurse may need to arrange for an ambulance pick-up.

I. *Arrival at the Hospital*

A. After the pt. arrives at the hospital, he/she will be taken to a private area.

B. If he/she is not accompanied by a cw, a hospital personnel will provide the pt. with emotional support until the cw arrives.

C. When the nurse meets the pt. she should extend emotional support to avoid additional anxiety and respect the sensitivity of the pt. at all times. Outline and explain all procedures including history, physical examinations, tests, possible medications. Point out that this is a routine examination. It may be helpful to repeat explanations in simple terms to children as you go along with the examination.

II. *Initial Screening*

A. Assess the pt.'s behavior and functioning and record. The physician will be taking a history, so do not attempt to elicit this. Minimize interrogative aspects and allow the pt. to verbalize as she wishes. The pt. may have a need to relate feelings and the facts regarding the assault before some of the above matters are considered; BE FLEXIBLE. The pt. may not want to share some of these facts initially; respect these wishes. The nurse or social worker/counselor who gives service to the pt. should have adequate training related to the psycho-social problems that rape victims and their families experience.

1. Describe the pt.'s behavior and affect. Ascertain whether the pt. has an adequate support system including family peers, and professional persons. Document impressions and anticipated reactions, changes.
2. Record carefully facts obtained and observations. In recording, state that the pt. alleges to have been molested, assaulted, etc.
3. Express your feelings pertinent to the need for a specialist's consultation to the physician involved. If the pt. arrives without advance notice, when notifying the on-call physician you should report any injuries, etc., that would require a specialist's care. The on-call physician would request you to obtain urine and fill out lab slips for:
    a. pregnancy test  
    b. spermatoza
4. Send the specimens to the lab immediately.

B. Check to see that written permission has been secured (consent form) from parent or guardian for examination and also for taking of photographs if necessary.

If the case is family oriented the completed Emergency Room history and physical with any lab information can, by law, be given immediately to the police, without written consent. Laboratory information subsequently obtained can be forwarded to the police and a copy to CPSC for the written report required by Child Abuse Law of Hawaii.

If the case is not family oriented, a consent for release of any information to police must be signed by the legally responsible person.

III. *Preparation for Medico-Legal Examination*

A. Obtain the locked box from the registered laboratory technician as outlined in the narrative description of the lock box procedure. This box must be signed out. Read the information in the box, check contents, and set up for use.

B. Present the physician with a brief summary of information obtained at the initial screening. The physician should refrain from re-asking questions of the pt. but may expand on them where indicated.

C. After the physician has taken the history, prepare the pt. for examination. Carefully explain the medical examination to the pt. if the cw has not done so. Help pt. undress and drape properly. Note torn or bloody clothing.

IV. *Medico-Legal Examination*

A. Assist with the vaginal examination. Moisten vaginal speculum with warm water for examination; *do not use lubricant.* Be aware of specimens needed as outlined in locked box procedure narrative.

V. *After the Medico-Legal Examination*

A. Follow the doctor's orders, i.e., offer the pt. a cleansing douche.

B. Review the need for Tetanus immunization update.

C. Continue to support the pt. psychologically.

D. If locked box cannot be returned to lab before you go off duty, it must be signed over to the on-coming nurse.

*Definitions:*

1. Incest as defined by Hawaii Law—i.e., "persons within the degree of consanguinity or affinity within which marriage is illegal."
2. Rape is assaultive sexual attack on any unwilling victim.
3. Statutory rape is carnal knowledge of any girl below a legally set age with or without her consent.

## *CRISIS WORKER ROLE*

The role of the crisis worker is to help the pt. by:

1. Either meeting him/her at the hospital, providing transportation to the hospital or arranging for ambulance, if necessary.
2. Providing him/her with companionship and emotional support.
3. Assisting him/her to fill out consent and registration forms.
4. Staying with him/her throughout the hospital procedures.
5. Taking care of his/her immediate needs upon discharge.
6. Preparing him/her to meet with the Kauikeolani Children's Hospital counselor or Child Protective Service social worker in the future to discuss additional concerns.
7. In the case of children, there is a need to extend your emotional support to the family. If the parents appear to be upset, initially you may need to focus your counseling efforts on them. It is important that the parent can provide a supportive atmosphere to the child after release from the hospital.

I. *Notification*

A. *Receiving call via hotline at Suicide Crisis Center*

When a call comes in through the Suicide Crisis Center hotline, the on-duty operator will connect the caller with:

1. Counselor/Coordinator, Monday-Friday, at Kauikeolani Children's Hospital, 531-3511, ext. 164.
2. Crisis workers at all other times.

B. *Situations may include:*

1. The Pt. Calls:

The pt. herself/himself may call after the alleged crime has taken place. This is truly a crisis situation and you will need to help the pt. make quick decisions and assess physical and emotional needs. Elicit basic information such as name, age, phone number and address. Let the pt. know you can meet him/her at an appropriate place decided by the two of you (e.g., hospital, police station, home). Advise him/her not to wash or douche or change clothes. If you will be meeting at some place other than home, make arrangements for him/her to get a change of clothes, if possible. Make arrangements for the pt. to be reconnected with phone specialist who will stay on the phone, if appropriate.

2. CPSC Worker Calls:

If a CPSC worker calls determine what services the worker will need. Discuss who will accompany the pt. through the hospital procedure. If you are to pick up the pt. get a phone number or address. Determine if the police, family members, hospital, etc., have been notified.

3. The Police Call:

A patrol officer or someone from the General Detail section of the Honolulu Police Department may call with the permission of the pt., before they have interviewed him/her and before he/she has been examined at the hospital. You will then meet or talk to the pt. and/or family members, as seems appropriate at that time.

4. The Hospital Calls:
   The hospital will call before the medico-legal examination. After receiving the hospital call, you will immediately go to the hospital.
5. Family or Friends Call:
   Family or friends may call, with or without the permission and knowledge of the pt., at varying times subsequent to the assault. Here you will need to find out when the assault took place and what other steps have been taken to notify police, hospital, or other appropriate people. You will meet and talk to the pt. and family or friends, as seems appropriate at that time.
   Remember that anything said to you about the pt. by family or friends should be kept in confidence, as, of course, is anything the pt. says.

C. *Contacting the Hospital*
   If you will be bringing the pt. to or meeting him/her at the hospital, notify the Emergency Room nurse immediately that a pt. will be arriving. Give her basic information such as the approximate time of arrival, the pt.'s physical and emotional needs, and whether you will be bringing or meeting the pt. at the hospital.

II. *Meeting the Pt. Outside the Hospital*
   A. See the pt. as soon as possible. Reassure and comfort him/her appropriately.
   B. When you meet the pt. for the first time, tell him/her immediately who you are, where you are from, and show your ID card. If you have talked to him/her on the phone, remind him/her of your conversation. If someone other than the pt. has called you, ask him/her permission to remain with them telling him/her how you might be helpful.
   C. Inform the pt. about the medical examination, tests, possible medications and the need for medico-legal information to be gathered.

III. *Arrival at the Hospital*
   A. *Crisis worker arrives with pt.*
      1. If you arrive at the hospital with the pt. or are meeting him/her there, notify the admitting clerk (who will call the Emergency Room nurse) and go with the pt. to a private area where you can talk.
      2. While you are waiting for the nurse, answer any questions that the pt. might have and provide the pt. with emotional support. If appropriate, explain to the pt. the arrangements that will be made for paying the medical costs. Inform her concerning procedures to be conducted, and reassure her regarding your role. Discuss reporting to police if not already done.
      3. When the pt. is ready, the cw can assist the pt. to fill out the registration and consent forms.
      4. The pt. may be undecided as to reporting the rape. The cw should explain the police and legal processes to the pt. Explain that the physician can document the presence or absence of semen and/or sperm on clothing and record this in the physical exam form and lab results for later use by the police. If the pt. agrees, the cw should notify the physician to do this testing.

IV. *Medico-Legal Examination*
   A. When the physician arrives, offer impressions of the pt.'s emotional status and social situation.
   B. The physician, cw and police will determine if the case is family or non-family oriented. (If the case is family-oriented, a CPSC worker must be notified as soon as possible through the hospital switchboard by the physician or his designate.) Note on the Crisis Worker's Report the determination of the case and if Child Protective Services worker arrived to assist in an emergency situation.
   C. The cw may be requested by the physician to provide emotional support to the pt. while he questions him/her regarding the assault. This will be at the physician's discretion.
   D. During the medico-legal examination the cw can provide support to the pt.'s family.

V. *After-the-Medico-Legal Examination*
   A. The cw will give the pt. an appointment slip for the medical follow-up and an information sheet on any medications given.
   B. The cw will explain follow-up services to the pt. The cw will explain that the KCH social worker or CPSC worker will be making telephone contact within 24 hours after the pt. has left the hospital. If it is a non-family oriented case, give the pt. the KCH social worker's name and phone number.
   C. The cw will take care of any immediate needs of a pt. before discharge, such as clothing, calling a CPSC worker for emergency placement, transportation or an escort home, as needed. Note planned or anticipated changes in housing. Obtain more than one telephone number or address for follow-up.
   D. Give the pt. the Criminal Compensation forms, information and other prepared materials.
   E. The cw can leave the cw report at the E.R. nursing station.
   F. If the pt. or family requests, the cw may stay during police questioning.

VI. *Follow-Up*

  A. The cw will leave the beeper at the Suicide and Crisis Center.

  B. The KCH counselor may contact the cw to get a verbal report on the day following the crisis or the KCH counselor can be contacted via the hotline if you wish to provide feedback to her.

  C. If a pt. currently involved in follow-up counseling with the KCH counselor, calls the hotline after hours in a crisis state, the cw will provide counseling. The following day the cw will provide feedback to the KCH counselor who will make arrangements for further follow-up.

## *ADMITTING CLERK'S ROLE*

The role of the admitting clerk is to:

1. Receive the pt. and expedite transfer to a private area or Emergency Room as quickly as possible;
2. Extend emotional support to avoid additional anxiety and to respect the sensitivity and privacy of the pt. at all times; and
3. Provide some flexibility in the completion of the registration and consent forms so as to allow for the pt.'s emotional needs to be met.

I. *Pt. Arrival at the Hospital without Advance Notice*

  A. Make an assessment of the pt.'s functioning. If the pt. appears agitated, upset, tearful, apprehensive or frightened, escort her to the Emergency Room and provide her with emotional support. Make the pt. feel as comfortable as possible by offering her something to drink, a magazine and kleenex if she is crying.

  B. Explain to her that a cw will be arriving to assist her and to accompany her during her examination at the hospital. A hospital personnel should stay with her until the cw arrives or arrange for a nurse to be with her.

  C. Call the emergency room and notify the E.R. nurse of the pt.'s arrival. The nurse will notify the on-call physician, the laboratory and the hotline.

  D. If the pt. appears in a calm state the admitting clerk can begin assisting the pt. to complete the forms before the cw arrives.

II. *Arrival of the CW*

  A. When the cw arrives give her the consent and registration forms and inform her where the pt. is. The cw will offer supportive counseling to the pt., explain hospital policies, get registration information and have consent forms signed. Registration will be completed after the cw is assured that the pt. is no longer upset and is emotionally prepared for the medico-legal examination.

  B. If a CPSC intake worker or other DSSH social worker arrives with the pt., and the KCH counselor, or a Suicide and Crisis Center cw is not called to assist in the case, the admitting clerk should assist the pt. in filling out the forms.

  C. The hormone therapy consent should *not* be signed. The physician will have the pt. sign this in the E.R. Any questions about the Law Enforcement agency form should be referred to the physician. He can have the form signed in the E.R.

  D. After the forms are completed the admitting clerk will review the consent form to be sure the information is complete and to give final epproval.

III. *Admitting a pt. for Hospitalization*

  A. If a pt. is admitted the diagnosis *should not* be rape, sex abuse, etc. Use a medical diagnosis such as laceration, injury, etc. to protect the pt.'s privacy.

## *RELEASE OF INFORMATION TO THE PRESS*

*Administrative Policy No. 74/05*

. . . "Release of Patient Information" . . . does not apply to SATC cases. Dr. Francis Terada is the official spokesperson regarding release of information to the press, or other interested agencies on sex abuse cases. In his absence, Dr. Ronald Berman, is authorized to act in his behalf. Under NO circumstances are other members of the hospital staff permitted to respond to inquiries on SATC cases.

## *MEMORANDUM OF AGREEMENT*

On September 22, 1976, a meeting was held in the Criminal Investigation Division conference room to finalize the ground rules on the handling of sexual abuse medical examinations at Kapiolani Hospital. The following guidelines were agreed upon:

1. It is agreed by the City and County Health Department that female victims of sex crimes who are 18 years of age and over will be examined at Kapiolani Hospital. Victims under 18 years of age will be examined at Kauikeolani Children's Hospital. However, minors that are brought to Kapiolani will be treated here and, as required by law, will be reported to the Child Protection Service Unit at Children's Hospital.
2. It is understood by all parties that any victim or a person legally qualified to make a decision on behalf of the victim may elect to have the victim examined by his or her personal physician. Examinations at either Kapiolani Hospital

or Children's Hospital will be conducted only after appropriate consent forms have been signed by the victim and/or a person legally qualified to give consent on behalf of the victim.

3. It is agreed that the medico-legal examinations will be done at no cost to the City and County of Honolulu.
4. It is agreed that examinations of victims at Kapiolani Hospital will include the necessary taking of smears and recording of other information pertinent to the determination of the extent of force employed by the assailant, resistance offered by the victim and whether or not penetration actually occurred. All such pertinent evidence and information, documented or otherwise, will be made available to the police upon written consent by the victim and/or a person legally qualified to give consent on behalf of the victim.
5. It is agreed that if the victim goes to the hospital before reporting the incident to the police, she will be encouraged by the crisis worker or other team members to file a report with the police. If the victim is adamant about not reporting the incident to the police, on the following day the center's counselor-coordinator will offer to file a third party report with the police.
6. It is understood that a female nurse will be present during the entire examination of the victim.
7. It is agreed that no penile wash of suspects will be conducted by Kapiolani Hospital.
8. It is agreed that clothing worn by the victim at the time of the attack will be turned over to the police upon consent of the victim and/or a person legally qualified to give consent on behalf of the victim. Alternate clothing for the victim will normally be provided by the victim's family or friends. If no family or friends are available, the police or the hospital will assist in working out an appropriate alternative.
9. It is agreed that all evidence requiring laboratory work shall be retained by Kapiolani Hospital. Handling of such evidence will be in accordance with the procedure established by the hospital, a copy of which is attached.
10. It is agreed that the examining physician will assist in the investigative procedure by posing necessary questions concerning sexual history and sensitive details of the act or acts involved in the assault. The medico-legal and sensitive questions forms are attached hereto.
11. It is agreed that physicians, crisis workers, nurses and technicians attached to the staff of Kapiolani Hospital will be available as necessary to testify in court concerning the examination and findings. Such testimony, court appearances or pre-trial interviews with the public prosecutor shall be at no cost to the City and County of Honolulu.

**THIS PORTION TO BE COMPLETED BY NURSE IN ATTENDANCE**

Vital Signs: WT.__________TEMP.__________B.P.__________PULSE__________RESP.__________

Allergies:____________________Medications:____________________

Nurse:____________________Date__________Time__________

(Signature) (Title)

**THIS PORTION TO BE COMPLETED BY PHYSICIAN IN ATTENDANCE**

**PRESENT ILLNESS**

Record of Assault: Date__________Time__________Location__________

PEDIATRICIANS: ASSAILANT: STRANGER ( ) ACQUAINTANCE ( ) GROUP ( )

FAMILY MEMBER ( ) SPECIFY__________

OB-GYN History: G_____ P_____ AB_____ LMP_____ Last Coitus__________

Current Contraception__________VD Hx (last 6 mo.)__________

**PRESENT HISTORY** (Continue on back of this page if more space is necessary)

**PAST HISTORY** Menstrual History: Age Onset__________Reg./Irreg.__________

Cycle__________ Duration__________

Major Illnesses:____________________

**PHYSICAL EXAMINATION** (Include all signs of physical and emotional trauma)

**THIS PORTION TO BE COMPLETED BY CRISIS WORKER IN ATTENDANCE**

EMOTIONAL STATE AND ORIENTATION (Include any *visible* physical injuries)

**PLAN** (include medication, follow-up, admission, referral, etc.)

1. Pregnancy prophylaxis (Morning After Therapy)
   - ___ Diethylstilbestrol (DES) 25 mg. bid for 5 d. given (patient has been informed of possible risks and side effects of such Rx if pregnancy were to occur)
   - ___ Not Given (contraindicated)
   - ___ Not Given (patient refused)
   - ___ Benedectine 1 tab. q6h prn nausea
2. Venereal Disease Prophylaxis
   - ___ Probenecid p.o. 1.0 gm. stat then Procaine Penicillin G 4.8 million units IM, divide dose ½ in each buttock
     or
   - ___ Probenecid p.o. 1.0 gm stat then Ampicillin p.o. 3.5 mg. stat
     or, if allergic to Penicillin
   - ___ Tetracycline 1.5 gm stat then 0.5 gm qid for 14 d. (if not pregnant)
   - ___ Spectromycin 4 gm IM (if pregnant)
3. ___ Tetanus Toxoid 0.5 cc IM
   (Reduce dosages in children accordingly)
4. Follow-up:
   - ___ Return to Ambulatory Care OB/GYN
   - ___ Return to Ambulatory Care Pediatrics (SATC Children's Follow-up Clinic)
   - ___ Return to PMD
   - ___ Follow up by CPS
   - ___ Plan for reporting to police
   - ___ Plan for reporting to parent__________
5. ____________________
6. ____________________
7. ____________________

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

I certify that the above specimens for evidence and laboratory studies were obtained from the above-named patient at Kapiolani-Children's Medical Center.

| | | | |
|---|---|---|---|
| Physician's Signature | Physician's Name (print) | Date | Time |
| Attending Physician's Signature | Attending Physician's Name (print) | Date | Time |

**PELVIC** (Include all signs of trauma, discharge, size, and development of reproductive organs; illustrate signs of trauma)

Vulva____________________________

Hymen____________________________

Vagina____________________________

Cervix____________________________

Fundus____________________________

Adnexae____________________________

Maturity Stage: ____pubic hair ____vulva

Rectal____________________________________________

**COLLECTION OF EVIDENCE** (check if done)

____ Ultraviolet Fluorescence—Draw Location:

____ Nail scraping ____ No fluorescence seen

____ Pubic Hair Combing

____ Pubic Hair Plucking

____ Clothing

____ Photographs (Photographs taken by:________________)

**LABORATORY STUDIES** (check if done)

____ Wet Mount (document absence or presence of sperm in #/HPF and % of sperm which are motile _____ sperm/HPF _____% motile sperm

____ Pap Smear

____ Acid Phosphatase

____ Gonorrhea Culture: ____ Endocervical ____ Vaginal ____ Rectal ____ Urethral ____ Oral

____ Serology (VDRL, RPR)

____ Urine (document results when available): PregnanTest—pos. ____ neg. ____
Presence of sperm—yes ____ no ____

____ X-rays (specify)________________________________________

____ Other (specify)________________________________________

**ASSESSMENT** Problems:
1. __________________________________
2. __________________________________
3. __________________________________

### *SENSITIVE AREAS OF A SEX ABUSE HISTORY*

CHECK ALL APPROPRIATE BLANKS

1. Did the assailant hurt you? ____ YES ____NO
2. PEDIATRICIANS: PLEASE COMMENT ON CHILD'S EMOTIONAL REACTION TOWARD SEX ABUSE INCIDENT:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

3. Did the assailant use force? What kind?
   (1) Verbal threats____________________________________________
   (2) Physical force (overpowering, hitting, where struck, etc.)____________________________
   __________________________________________________________

Were you bitten? ___ Yes ___ No Where? ______________________________

(3) Weapons used______________________________

Injuries sustained from weapons______________________________

(4) Other (describe)______________________________

______________________________

4. Did you feel his penis? ___ YES ___ NO ___ Don't Know

a. Was it hard? ___ YES ___ NO ___ Don't Know

b. Outside you? ___ YES ___ NO ___ Don't Know

(If yes, where on your body?)______________________________

c. Inside you? ___ YES ___ NO ___ Don't Know

1) If yes, inside: vagina ___ YES ___ NO ___ Don't Know

mouth ___ YES ___ NO ___ Don't Know

anus (rectum) ___ YES ___ NO ___ Don't Know

2) (If patient is sexually naive)—Does tampon feel like what was put inside you?) ___ YES ___ NO ___ Don't Know

(If necessary, ask again during medical examination)—
Does finger or speculum feel like what was put inside you?

___ YES ___ NO ___ Don't Know

5. Did assailant reach a climax? ___ YES ___ NO ___ Don't Know

a. If answer is *YES:*

1) Did he climax inside you? ___ YES ___ NO ___ Don't Know

Specify: vagina ___ anus (rectum) ___ mouth ___

2) Did he climax outside you? ___ YES ___ NO ___ Don't Know

(If yes, where on your body?)______________________________

b. If answer is *NO* or *Don't Know*, continue with:

1) Did any liquid run out from inside you afterwards?

___ YES ___ NO ___ Don't Know

Specify: vagina ___ anus (rectum) ___

6. Did assailant wear a condom? ___ YES ___ NO ___ Don't Know

7. Did assailant place his mouth on your genitals (cunnilingus/fellatio?)

___ YES ___ NO ___ Don't Know

8. Did assailant insert foreign objects into your vagina or anus (rectum)?

___ YES ___ NO ___ Don't Know

9. Were any of these acts performed more than once?

___ YES ___ NO ___ Don't Know

Specify:______________________________

______________________________

10. Have you had intercourse after the attack and before reporting to the police? ___ YES ___ NO ___ Don't Know

11. Is there any chance you were pregnant before the assault? ___ YES ___ NO ___ Don't Know

12. Did you:

(1) Bathe? ___ YES ___ NO ___ Don't Know

(2) Douche? ___ YES ___ NO ___ Don't Know

(3) Change your clothes? ___ YES ___ NO ___ Don't Know

(4) Rinse your mouth or brush your teeth? ___ YES ___ NO ___ Don't Know

13. (Optional for OB/GYN):

a. Did assailant touch your breasts? ___ YES ___ NO ___ Don't Know

b. Was there oral contact with your breasts? ___ YES ___ NO ___ Don't Know

c. Did assailant touch other areas of your body not previously mentioned? ___ YES ___ NO ___ Don't Know

Specify:______________________________

______________________________

d. Did assailant force you to touch his genitals? ___ YES ___ NO ___ Don't Know

______________________________

Physician's Signature

______________________________

Physician's Name (Please print)

______________________________

Date

### Request for Special Examination—Investigation of Alleged Sexual Abuse

Medical Record Number____________ Patient Initials____________

A. FEMALES

1. Direct vaginal wash sediment for spermatozoa ____________
2. Acid phosphatase of vaginal washing ____________
   ________cc of saline used in washing
3. Cultures for gonorrhea:
   a. Vaginal—endocervical ____________
   b. Rectal ____________
   c. Throat ____________
4. Urine—fresh voided
   a. Pregnancy test ____________
   b. Spermatozoa ____________
5. Papanicolaou smears ____________
6. Serology for syphilis ____________
7. Others: specify ____________
   ____________
   ____________

B. MALES

1. Rectal smear for spermatozoa ____________
2. Cultures for gonorrhea:
   a. Penile-urethral ____________
   b. Rectal ____________
   c. Oral ____________
3. Serology for syphilis ____________
4. Others: specify ____________
   ____________
   ____________

I certify that the above specimen(s) was/were obtained from the above identified patient on

____________ Date ____________ Time

____________ Witness ____________M.D.

7/78

## *CONSENT FOR MORNING AFTER PILL*

Diethyl Stilbesterol can only be considered as an emergency treatment against pregnancy. DES is not approved for this use by the Federal Drug Administration (FDA), however, its usefulness and safety have been confirmed at Yale University.

There are side effects of treatment:

1. Headaches, nausea and vomiting are most common;
2. Menstruation may be altered: late, light flow and spotting;
3. There is a slight possibility that pregnancy can occur. As with any drug taken during pregnancy, it can affect the fetus.

I have been given the information sheet on the Morning-After Pill. The physician has informed me of the benefits, risks, side effects and limitation of DES and that DES is not approved for preventing conception by the FDA, but has been shown to be effective in this capacity, as explained in the information sheet. I further acknowledge that a procedure of termination of pregnancy is urged should the Morning-After Pill fail and I become pregnant.

I have had the opportunity to have any questions concerning the Morning-After Pill answered and consent to treatment.

______________________________ ______________

Patient's Signature (parent or guardian if a minor or if mentally incompetent) Relationship

______________________________

Signature of Witness

______________________________

Date

---

## CONSENT FOR EMERGENCY TREATMENT-OUTPATIENT SERVICES

This is to certify that I (we) the undersigned consent to the administration of whatever anesthetics and treatments and the performing of whatever operations may be decided to be necessary or advisable in the opinion of the attending physician.

The hospital is authorized to furnish from patient's record requested information or excerpts to any insurer of patient for the purpose of remuneration of the hospital for services provided the insured.

______________________________ Relationship______________

(Patient's Signature, Parent or Guardian, if a minor, Guardian if mentally incompetent)

Witness:______________________________ Date:______________

## CONSENT TO PHOTOGRAPH

I hereby grant to Kapiolani-Children's Medical Center, Sex Abuse Treatment Center, permission to photograph ____________.
I understand that these photographs will become part of my medical record. I further understand that the only other use to which such photographs shall be put shall be for law enforcement evidentiary purposes on the express permission of the patient (guardian).

______________________________ Relationship______________

(Patient's Signature, Parent or Guardian if a minor, Guardian if mentally incompetent)

Witness:______________________________ Date:______________

## CONSENT TO RELEASE INFORMATION TO PRIVATE PHYSICIAN

I hereby grant permission to Kapiolani-Children's Medical Center, Sex Abuse Treatment Center to release to ____________ any and all information from my records which may be pertinent to a better understanding of my case.

______________________________ Relationship______________

(Patient's Signature, Parent or Guardian if a minor, Guardian if mentally incompetent)

Witness:______________________________ Date:______________

## CONSENT TO USE DATA FROM PATIENT'S MEDICAL RECORD

I hereby grant permission to Kapiolani-Children's Medical Center, Sex Abuse Treatment Center to use any information from any record compiled by the SATC in connection with service I receive as a SATC patient. I understand that such use shall be exclusively for evaluation of the SATC program, research, official reports required by public or private funding agencies. I further understand that such use shall be for data collection and analysis only and shall not identify me by name or otherwise.

______________________________ Relationship______________

(Patient's Signature, Parent or Guardian if a minor, Guardian if mentally incompetent)

Witness:______________________________ Date:______________

Case #__________

## AUTHORIZATION FOR RELEASE OF INFORMATION TO LAW ENFORCEMENT AGENCY

| | | Authorized for Release | Released | Transferred to Evidence Box |
|---|---|---|---|---|
| 1. | medico-legal record (only xeroxed copy of record should be released to police) | | | |
| 2. | copies or reports of x-rays taken | | N.A. | N.A. |
| 3. | pathology report (test results) | | N.A. | N.A. |
| 4. | clothing | | | |
| 5. | film | | | |
| 6. | fingernail scrapings | | | |
| 7. | pubic hair combing | | | |
| 8. | pubic hair plucking | | | |
| 9. | other (specify)____________________ | | | |
| | ____________________ | | | |

I hereby authorize Kapiolani-Children's Medical Center, Sex Abuse Treatment Center to release the items marked "Authorized for Release" to a Law Enforcement Agency.

Signature of Patient (parent or guardian if a minor or if mentally incompetent) ____________________ Date ____________

Signature of Witness ____________________ Date ____________

## RECEIPT AND TRANSFER OF SPECIMENS/INFORMATION

I hereby certify that I have released the above information/specimens marked "Released" to a Law Enforcement representative.

Name of Person Releasing Specimens (please print) ____________________

Signature of Person Releasing Specimens ____________________

I hereby certify that I have received the above information/specimens marked "Released" from a SATC representative.

Name of Person Receiving Specimens (please print) ____________________

Signature of Person Receiving Specimens ____________________

Date ____________

Time ____________

## CONSENT BY MINOR 14-18 YEARS OF AGE TO DO HISTORY AND PHYSICAL EXAMINATION FOR VENEREAL DISEASE AND PREGNANCY

I, ________________________________________, hereby give my consent to the providing of medical care and service by Kauikeolani Children's Hospital for pregnancy ☐ venereal disease ☐ including permission for a history and physical examination involving laboratory tests to be done on myself.

MEDICAL RECORD #____________ ____________

Patient's Signature____________________

Patient's Age____________

Witness:____________________

Date:____________________

# APPENDIX B

## Guides for Parents Concerning the Sexual Abuse of Children

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# Sexual Abuse of Children
# A Guide for Parents
### Queen's Bench Foundation
### San Francisco—1977

Sexual abuse affects hundreds of children in the Bay Area every year. Sex acts children suffer range from fondling to intercourse and sodomy. While some children are grabbed by strangers in dark alleys; many, many more are abused by people they know and trust. Both boys and girls may be victims of sexual abuse, and children as young as 6 months old have been attacked. The problem is not limited to economically disadvantaged families or to certain ethnic groups.

Abusers, too, come from all ethnic groups and all social classes. They are employed in every sort of occupation or profession and are often widely respected in their communities. The overwhelming majority of them are male. They range from adolescents to older men, but most are under 50 years old.

A study of sexually abused children conducted by the American Humane Association (1969) reported these findings;

**75% of the offenders were known to the child or the child's family before the abuse. In fact 27% of them were members of the child's household.

**In 72% of the cases, parents contributed to the abuse by acts of omission or commission.

**In about half the cases, the child didn't tell anyone about the incident until more than a week later. Often, children feared parents would be angry and punish them for what happened.

No one likes to think about sexual attacks on children; but if parents face the reality of the problem, they may be able to help their children escape the guilt, anxiety, and fear experienced by many boys and girls who are sexually abused.

## HOW CAN I PROTECT MY CHILDREN FROM SEXUAL ABUSE?

It is difficult to protect your children from abuse by family members and close friends, but you can be alert to *many* other potentially dangerous situations.

***Be aware of where your children are and what they are doing.* Your mindful supervision is their best protection against sexual abuse. Of course, you won't be with them all the time. Ask another responsible adult to watch them when you aren't there to care for them yourself. If you can't find adult supervision, arrange for them to walk or play in a group.

***Know who is with your children.* If you are hiring a babysitter for the first time, ask for references and be sure to check them. Inquire about people who offer your son or daughter a job, particularly if it involves working in their home. Get to know your children's friends, especially those who are a few years older than your son or daughter.

***Teach your children to watch out for their own safety.* Remind them not to accept money or favors from strangers. Warn them never to accept a ride or go anywhere with someone they don't know. Talk about what your children can do if someone approaches them.

## WHAT *CAN* CHILDREN DO IF SOMEONE APPROACHES THEM?

**Tell your children to seek help immediately if an adult makes them feel uneasy or afraid. Tell them to run away and scream for help. Explain that it's alright to attract attention and create a scene in these situations.

**Remember that many children are abused by adults they know. Tell your children that they don't have to agree to demands for physical closeness. Assure them that it's alright to say no—even to close friends and relatives.

**Encourage your children to tell you or another adult immediately if anyone touches or talks to them in a way that seems strange or makes them uncomfortable.

## HOW CAN I TALK TO MY CHILDREN ABOUT SEXUAL ABUSE WITHOUT SCARING THEM?

You have already taught your children many safety rules—how to cross busy streets, what to do when they get hurt, and so on. Precautions relating to sexual abuse can be a natural part of your discussion of safety in general. Set rules that are appropriate to each child's age and development, and change them as the child grows up.

You don't have to tell very young children about sex when you discuss these rules if you don't want to. Simply explain that some adults may try to take off children's clothes or touch them in a way that makes them feel uncomfortable.

Be sure to use words your children understand. Answer questions fully, and let your children know that they can come to you at any time to talk about anything that is puzzling or upsetting. Your calm, matter-of-fact manner will reassure your children that they can share their concerns with you in the future.

### WON'T MY CHILDREN BECOME SUSPICIOUS AND MISTRUSTING OF ALL ADULTS?

Children know that some adults cannot control themselves—they may drink too much or lose their tempers, for example—and they know that some adults make mistakes. Your children can understand the sex offender in this context. You can help them remember that molesters are the exception rather than the rule by providing opportunities to be with adults who are warm and understanding. Show your children safe ways to relate to strangers while you are there to protect them.

### HOW DO CHILDREN REACT TO SEXUAL ABUSE?

Children's reactions to sexual abuse differ with their age and personality and with the nature of the offense. Sometimes children are not upset even by crimes which seem very serious to their parents. Often, children are frightened or confused by sexual abuse.

Many children are afraid to tell anyone about the incident for fear of being blamed or punished. In other cases, children remain silent because they don't want to "make trouble" for the offender. Older children may be too embarrassed to describe the incident. These problems are especially common when the offender is someone close to the family.

Even if your child doesn't tell you about the abuse, you may be aware that something is wrong. Changes in appetite or sleep patterns may be a clue, or your child may seem unusually withdrawn. S/He may be very upset whenever you leave or when the offender is nearby. Be sensitive to changes in your child's behavior and try to find out what's behind them.

### HOW SHOULD I RESPOND IF MY CHILD TELLS ME S/HE'S BEEN ABUSED?

*Be aware of your feelings about the incident.*

You may be upset yourself by what happened to your child. You may feel guilty, angry, or shocked. If you feel angry, make sure your son or daughter understand that you are angry with the offender, not the child.

Your first reaction may be disbelief. Children do tell tales, but they very rarely report imaginary sexual relations with adults. Take your child's story seriously even if the offender is someone you thought you could trust.

Many parents feel completely helpless when their child is abused, but you really can do a lot to help. In fact, your reaction will be the most import factor in how your child readjusts.

*No matter how you are feeling, remember that your child's welfare is your first concern.*

If you are very upset, you should pause for a moment to collect your thoughts before talking to your child about the incident. Explain to your son or daughter that you are upset by what happened and that you understand that s/he may be upset, too.

Reassure the child of your concern and ask him/her to tell you about the incident. Don't pressure your son or daughter to talk, but do make yourself available and listen carefully if s/he wants to tell you about the experience. Answer any questions and clarify misunderstandings. Emphasize that the offender, not the child, is to blame. Tell the child that you will protect him/her from having a similar experience in the future.

Other children in your family may also be upset by the incident. Be aware of their needs for attention and understanding.

Children are rarely seriously injured by sex offenders, but you may want to seek medical care. Internal injuries may be difficult to recognize. Your child can be examined without charge at Central Emergency Hospital (see P. 8), or you may consult your family doctor.

### WHAT IF THE OFFENDER IS IN MY IMMEDIATE FAMILY?

This situation would be extremely difficult for your child and for other family members. You may have strong, conflicting feelings about the offender; but protection of the child must remain your first priority. Agencies listed on page 8 can offer assistance, and the Child Sexual Abuse Treatment Program is particularly concerned with helping families with this problem. (Santa Clara County Juvenile Probation Department, 840 Guadalupe Parkway, San Jose, California 95110. Telephone: (408) 299-2475).

### WILL MY CHILD BE ALL RIGHT?

Permanent physical damage as a result of sexual assault is very rare. Your physician can discuss any injuries with you. Your child's emotional recovery will depend, in large part, on your response to the incident.

The period of readjustment after the abuse can be difficult for both parent and child. Many youngsters continue to be frightened and upset for several weeks. They may have difficulty eating and sleeping, and they may be anxious about returning to school.

Often children need to talk about the abuse over and over again. You can help by being ready to listen and answer questions. Children are apt to feel guilty for what happened. Clarify that they are not to blame.

Even if your child doesn't talk about the incident, don't assume s/he's forgotten, and don't pretend it never really happened. Your openness and understanding will help heal emotional wounds left by the abuse.

If your child seems to be extremely upset or if s/he hasn't resumed her/his normal routines in a couple of weeks, look for professional advice. Remember, too, that you and others in your family may be troubled by the abuse. Your physician, school counselor, or clergyman may be able to help; and a professional at the Child & Adolescent Sexual Abuse Resource Center (S.F.G.H.—Children's Health Center) can talk to you about other resources.

# WHAT IF YOUR CHILD TELLS YOU SHE OR HE HAS BEEN SEXUALLY MOLESTED?

**Prepared by:**
**Sexual Assault Center**
**Harborview Medical Center**
**Seattle, Washington**

**Be aware that:**

1. Children are usually molested by people they know—often a relative or friend of the family.
2. Children are usually not violently attacked or hurt physically during a sexual assault.
3. Children very seldom lie about such a serious matter.
4. Not all children are able to tell parents directly that they have been molested. Changes in behavior, reluctance to be with a certain person or go to a certain place may be signals that something has happened.

**What to do immediately:**

1. Go with the child to a private place. Ask the child to tell you what happened in her/his own words, and listen carefully.
2. Tell her/him s/he did well to tell you, that you are very sorry this happened, and that you will protect her/him from further molestation.
3. If you suspect your child has an injury, contact your regular physician or Harborview Medical Center's Emergency Room immediately.
4. You may call the police immediately and a uniformed officer will come to your house to take an initial report.
5. You may call the Sexual Assault Center, 223-3047/223-3010 (Emergency Room Social Worker) for advice and information about what to do. 632-RAPE and Children's Protective Services, 464-7333, are also available 24 hours/day.

**Helping your child following the assault:**

1. Continue to believe your child and do not blame your child for what happened.
2. Consult with your physician or the Sexual Assault Center regarding need for medical examination.
3. Instruct your child to tell you immediately if the offender attempts sexual molestation again or bothers her/him in any way.
4. Give your child reassurance and support that s/he is okay.
5. Respond to questions or feelings your child expresses about the molestation with a calm, matter-of-fact attitude but do not pressure your child to talk about it.
6. Respect privacy of child by not telling a lot of people or letting other people question her/him.
7. Try to follow regular routine around the home (expect usual chores, bedtimes, rules).
8. Inform brothers/sisters that something has happened to child but that s/he is safe and will be okay. Do not discuss details of assault with brothers/sisters. Make sure that all children in the family are given enough information to protect themselves from the assailant.
9. Take the time to talk it over privately with someone you trust—your spouse, a friend, a relative, a counselor; express your feelings. Do not discuss situation in front of your child/children.

**Most common immediate problems of sexually molested children:**

1. Sleep disturbances (nightmares, fear of going to bed, wanting light on, waking up during night, fear of sleeping alone).
2. Loss of appetite.
3. Irritability, crankiness, short-tempered behavior.
4. Bedwetting.
5. Needing more reassurance than usual, clinging to parent.
6. Changes in behavior at school or in relating to friends.
7. Fears.
8. Behaving as a younger child (regression).
9. The adolescent may also act out his/her feelings, i.e., running away, skipping school, being rebellious.

**These are normal signs of upset. Your child may have some of these problems or none at all. They usually will last a couple of weeks. Try to notice all changes in usual behavior, and discuss with your counselor.**

**No one knows for sure about long-term emotional effects, but we believe that if the situation is handled in a direct and sensitive way at the time it is revealed, your child need not suffer permanently from the assault.**

**Contact the Sexual Assault Center, 223-3047, for help: medical care; counseling for parents and the child; reporting to police and going to court; getting help for the offender; and any other concerns. You are not alone.**

**A report must be made to Children's Protective Services if there is any potential further abuse of the child.**

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# APPENDIX C

## Child Sexual Abuse Treatment Programs

# Child Sexual Abuse Treatment Programs

NOTE: The following list consists of programs that were either developed exclusively to treat child sexual abuse or that incorporate special components and resources to deal with some aspect of this problem. The list is far from exhaustive; it contains only those programs that are known to the National Center or are included in its annual edition of *Child Abuse and Neglect Programs*, containing descriptions of over 2200 programs in the United States. Sexual abuse cases are also handled by Protective Services Units of state and county Departments of Social Services as well as by many Rape Crisis and Mental Health Centers. Any specialized child sexual abuse programs that are not included in this list are encouraged to write to the NCCAN Clearinghouse, P.O. Box 1182, Washington, D.C., 20013, for a form on which they can describe their programs. Program descriptions will be included in the next edition of *Child Abuse and Neglect Programs*.

## ALASKA

The Judith Group
Box 2334
Soldotna, Alaska 99669

## ARIZONA

Behavior Associates
330 E. 13th Street
Tucson, Arizona 85701

Tucson Center for Women and Children
419 South Stone Avenue
Tucson, Arizona 85701

Center Against Sexual Assault
137 West McDowell Road
Phoenix, Arizona 85003

## ARKANSAS

S.C.A.N. (Suspected Child Abuse/Neglect)
Hendrix Hall
4313 West Markham
Little Rock, Arkansas 72201

Alcohol/Child Abuse Treatment Project
Univ. of Arkansas School of Social Work
33rd and University
Little Rock, Arkansas 72204

## CALIFORNIA

Child Sexual Abuse Treatment Program
Santa Clara County Juvenile Center
840 Guadalupe Parkway
San Jose, California 95110

Parents United, Inc.
826 N. Winchester Blvd., Suite 1-A
San Jose, California 95128

Sexual Abuse Treatment Program
Valley Psychiatric Center
15243 Van Owen, Suite 312
Van Nuys, California 91405

Riverside Council on Child Sexual Abuse
Riverside County Children's Mental
Health Community Services
3876 Sixth Street
Riverside, California 92501

Child Sexual Abuse Treatment Program
Arlington Dept. of Social Services
Child Protective Services
3950 Reynolds
Riverside, California 92503

New Alternatives—Horizon House
Residential Treatment Center for
Sexually Abused Girls
3602 Kenora Drive
Spring Valley, California 92007

Child Sexual Abuse Project
Dept. of Public Social Services
5427 Whittier Blvd.
Los Angeles, California 90022

Community Consultation Service
Harbor General Hospital, Unit 5-D
1000 Carson Blvd.
Torrance, California 90509

Child Sexual Abuse Project
Los Angeles Dept. of Social Services
3401 Rio Honda Avenue
El Monte, California 91731

Family Stress Center
YWCA of San Diego County
3142 Plaza Blvd.
National City, California 92050

Sexual Abuse Program
Children's Hospital and Medical Center
8001 Frost Street
San Diego, California 92111

Child Sexual Abuse Treatment Program
Dept. of Public Welfare
Dependent Children Section
6950 Levant Street
San Diego, California 92111

Marin County Child Sexual Abuse
Treatment Program
P.O. Box 4160
Room 261 D, Civic Center Branch
San Rafael, California 94903

Child Sexual Abuse Treatment Program
Department of Social Services
875 Woodside Avenue
San Francisco, California 94127

Child Sexual Abuse Resource Center
San Francisco General Hospital
1001 Potrero Avenue
San Francisco, California 94110

Kairos Crisis Home for Girls
6001 Camden
Oakland, California 94605

Child Sexual Abuse Treatment Program
Child Protective Services
401 Broadway
Oakland, California 94607

San Fernando Valley Child
Guidance Clinic
Outpatient Treatment Services
9650 Zelza Avenue
Northridge, California 91325

Mid-Valley Incest Treatment Program
Mid-Valley Community Mental Health
Council
P.O. Box 414
Durate, California 91010

Child Sexual Abuse Treatment Program
Dept. of Health and Welfare
225 W. 37th Avenue
San Mateo, California 94033

Sexual Assault Prevention Program
Didi Hirsch Community Mental Health
Center
4760 S. Sepulveda Blvd.
Culver City, California 90230

Child Sexual Abuse Treatment Program
Child Protective Services
85 Cleveland Road
Pleasant Hill, California 94523

Family Crisis Center
Fresno Co. Child Protective Services
1044 Fulton Mall
Room 519
Fresno, California 93721

Child Sexual Abuse Treatment Team
Child Protective Services
929 Koster Street
Eureka, California 95501

Child Sexual Abuse Treatment Program
Henrietta Weill Memorial Child
Guidance Clinic
804 11th Street
Bakersfield, California 93303

Crisis House
South Monteray County Community
Counseling Center
255 East Street
Soledad, California 93906

Child Sexual Abuse Treatment Program
Department of Social Services
P.O. Box 1060
Ukiah, California 95482

Child Sexual Abuse Treatment Program
Mendocino Co. Mental Health
860 A North Bush Street
Ukiah, California 95482

Child Sexual Abuse Treatment Program
Department of Mental Health
401 East Cypress
Lompoc, California 93436

Victims Anonymous
Northridge/Reseda Community Mental
Health Center
18356 Oxnard Street
Tarzana, California 91356

Child Sexual Abuse Treatment Program
Napa County Mental Health Outpatient
Service
2344 Old Sonomo Road
Napa, California 94558

Child Sexual Abuse Treatment Program
Department of Social Services
1623 West 17th Street
P.O. Box 1944
Santa Ana, California 92702

Child Sexual Abuse Treatment Program
Department of Mental Health
Child/Adolescent Program
700 E. Gilbert Street, Bldg. 4
San Bernadino, California 92415

Child Sexual Abuse Treatment Program
The Parent's Center
532 Soquel Avenue
Santa Cruz, California 95061

Child Sexual Abuse Treatment Program
The Parent's Center
406 Main Street
Watsonville, California

Child Sexual Abuse Treatment Program
Sunrise House
116 East Ailsal
Salinas, California 93901

Child Sexual Abuse Treatment Program
Family Resource Center
500 Hillby Avenue
Seaside, California

Child Sexual Abuse Treatment Program
Simi Conego Children's Program
Ventura County Mental Health
1925 Royal Avenue
Simi Valley, California 93065

Child Sexual Abuse Treatment Program
Solano County Mental Health
1408 Pennsylvania
Fairfield, California 94533

Victim Assistance for the Sexually Traumatized
Community Counseling and Education Center
38218 Glenmoor Drive
Freemont, California 94536

## COLORADO

Family Therapy Program
Children's Hospital
1056 East 19th Street
Denver, Colorado 80218

National Center for the Prevention and Treatment of Child Abuse
1205 Oneida Street
Denver, Colorado 80220

Boulder Co. Sexual Abuse Program
3400 Broadway
Boulder, Colorado 80302

Child Sexual Abuse Treatment Program
Univ. of Colorado Medical Center
4200 East 9th Avenue
Denver, Colorado 80262

Child Protective Services
El Paso Co. Dept. of Social Services
P.O. Box 2692
105 N. Spruce
Colorado Springs, Colorado 80901

## CONNECTICUT

Sex Offender Program
Connecticut Dept. of Corrections
P.O. Box 100
Somers, Connecticut 06071

## DISTRICT OF COLUMBIA

Child Sexual Victim Assistance Project
Child Protection Center
Children's Hospital National Medical Center
111 Michigan Avenue
Washington, D.C. 20010

Sexual Abuse Prevention Program
D.C. Rape Crisis Center
P.O. Box 21005
Washington, D.C. 20009

## FLORIDA

The Rape Treatment Center
Jackson Memorial Hospital
1700 N.W. Tenth Avenue
Miami, Florida 33136

Child Development Center
Community Mental Health Center of Escambia County
1201 W. Herndez
Pensacola, Florida 32501

Child Sexual Abuse Treatment Program
Tampa Women's Health Center, Inc.
3004 Fletcher
Tampa, Florida 33612

Victim-Court Liaison Services
State Attorney, 9th Judicial Circuit
P.O. Box 1673
Orlando, Florida 32802

## GEORGIA

Rape Crisis Center
Grady Memorial Hospital
80 Butler Street, S.E.
Atlanta, Georgia 30303

## HAWAII

Sexual Abuse Treatment Center
Kapiolani Children's Hospital
1319 Punahoo Street
Honolulu, Hawaii 96826

Child Sexual Abuse Treatment Program
Catholic Social Services
250 S. Vineyard Street
Honolulu, Hawaii 96813

## ILLINOIS

Childhood Sexual Abuse Project
CAUSES
836 West Wellington Avenue
Chicago, Illinois 60657

The Child Advocate Association
19 South LaSalle Street, #401
Chicago, Illinois 60603

Parental Stress Services
409 Dearborn
Room 590
Chicago, Illinois 60605

Child Sexual Abuse Treatment Program
Community Service Council of
Northern Illinois
757 Luther Drive
Romeoville, Illinois 60441

Council on Children-At-Risk
1630 Fifth Avenue
Room 226
Moline, Illinois 61265

## KANSAS

Wyandotte Co. Mental Health Center
Eaton at 36th Street
Kansas City, Kansas 66103

Johnson Co. Mental Health Center
539 East Santa Fe
Olathe, Kansas 66016

Child Sexual Abuse Treatment Program
Child Protective Services
Dept. of Social and Rehabilitation
Services
1 Patrons Plaza
Olathe, Kansas 66061

## MAINE

Project Response
232 Main Street
Waterville, Maine 04330

## MARYLAND

Sexual Abuse Treatment Program
Baltimore City Dept. of Social Services
312 East Oliver Street
Baltimore, Maryland 21202

Sexual Assault People Program
Baltimore City Hospitals
Dept. of Medical Social Work
4940 Eastern Avenue
Baltimore, Maryland 21224

The Sex Offense Task Force
Baltimore State's Attorney's Office
Criminal Courts Bldg.
Baltimore, Maryland 21202

Sexual Abuse Treatment Program
Baltimore Co. Dept. of Social Services
620 York Road
Towson, Maryland 21204

Child Sexual Abuse Program
Protective Services Unit
Montgomery Co. Dept. of Social Services
5630 Fishers Lane
Rockville, Maryland 20852

Multidisciplinary Committee on
Physical and Sexual Abuse and Neglect
Anne Arundel Co. Department of
Social Services
Arundel Center, Calvert Street
Annapolis, Maryland 21404

## MASSACHUSETTS

Sexual Abuse Treatment Team
Children's Hospital Medical Center
300 Longwood Avenue
Boston, Massachusetts 02115

Victim Counseling Service
Boston City Hospital
Department of Nursing Services
818 Harrison Avenue
Boston, Massachusetts 02118

Protective Services Unit
Massachusetts Department of
Public Welfare
75 Commercial Street
Brockton, Massachusetts 02402

Center for the Diagnosis and Treatment
of Sexually Dangerous Persons
Massachusetts Dept. of Mental Health
Bridgewater, Massachusetts

Somerville Women's Mental Health
Collective
61 Rosland
Somerville, Massachusetts

## MICHIGAN

Child Sexual Abuse Treatment Program
Children's Aid Society
71 West Warren Street
Detroit, Michigan 48201

Genessee Co. Child Abuse Consortium
6th Avenue and Begole
Flint, Michigan 48502

Lutheran Children's Friend Society
Bay City Office
304 Tuscola Road, P.O. Box E
Bay City, Michigan 48707

## MINNESOTA

Family Sexual Abuse Project
Family Renewal Center
Fairview Southdale Hospital
6515 Barrie Road
Edina, Minnesota 55435

Christopher Street, Inc.
Incest Program
2344 Nicollet Avenue So.
Minneapolis, Minnesota 55405

Sexual Assault Services
Hennepin Co. Attorney's Office
2000 C Government Center
Minneapolis, Minnesota 55414

Child Sexual Abuse Treatment Program
East Side Neighborhood Service, Inc.
1929 Second Street N.E.
Minneapolis, Minnesota 55418

Child Protection Intake Unit
Ramsey Co. Welfare Department
160 East Kellogg Blvd.
St. Paul, Minnesota 55101

Program in Human Sexuality
Dept. of Family Practice
Univ. of Minnesota Medical School
Research East Bldg.
2630 University Avenue S.E.
Minneapolis, Minnesota 55414

Chrysalis Center for Women, Inc.
2104 Stevens Avenue So.
Minneapolis, Minnesota 55404

Face to Face Counseling Service
730 Mendota
St. Paul, Minnesota 55106

Child and Adolescent Services
Ramsey Co. Mental Health Center
529 Jackson Street
St. Paul, Minnesota 55101

Sexual Abuse Counseling Team
Wilder Child Guidance Clinic
919 Lafond Avenue
St. Paul, Minnesota 55104

## MISSOURI

Child Sexual Abuse Management Program
St. Louis Children's Hospital
500 South Kingshighway Blvd.
P.O. Box 14871
St. Louis, Missouri 63178

Child Sexual Abuse Treatment Program
Christian Family Life Center
6636 Clayton Road
St. Louis, Missouri 63117

## NEW JERSEY

Incest Counseling Program
Mercer Co. Division of Youth and
Family Services
1901 North Olden Avenue
Trenton, New Jersey 08618

Family Service of Burlington Co.
Meadow Health Center
Woodlane Road
Mount Holly, New Jersey 08060

Atlantic County Adolescent
Maltreatment Project
Division of Youth And Family Services
26 S. Pennsylvania Avenue
Atlantic City, New Jersey 08401

Dept. of the Public Advocate
Law Guardian Program
P.O. Box 141
Trenton, New Jersey 08625

Adult Diagnostic and Treatment Center
Rahway Prison
P.O. Box 190
Avenel, New Jersey 07001

### NEW MEXICO

Sexual Abuse Demonstration Project
New Mexico Dept. of Human Services
Family Resource Center—Team 3
919 Vassar N.E.
Albuquerque, New Mexico 87106

### NEW YORK

New York Society for the Prevention
of Cruelty to Children
110 East 71st Street
New York, New York 10021

Brooklyn Society for the Prevention
of Cruelty to Children
P.O. Box 423
Times Plaza Station
Brooklyn, New York 11787

Queensboro Society for the Prevention
of Cruelty to Children
161-20 89th Avenue
Jamaica, New York 11432

Sex Crimes Prosecution Unit
New York County Office of the
District Attorney
155 Leonard Street
New York, New York 10013

Victims Information Bureau of
Suffolk County (VIBS)
501 Route 111
Hauppague, New York 11787

Unified Services for Children and
Adolescents
33 Second Street
Troy, New York 12180

Alliance—Child Abuse Coordination
Program
Catholic Charities
Family Services Division
1654 West Onondaga Street
Syracuse, New York 13204

### NORTH CAROLINA

North Carolina Sexual Abuse
Identification and Treatment Project
Department of Human Resources
Dept. of Social Services
325 N. Salisbury Street
Raleigh, North Carolina 27611

### NORTH DAKOTA

Rape Crisis Center
Grard Forks Co. Social Services Center
118 North 3rd Street
Grand Forks, North Dakota 58201

### OHIO

Sexual Abuse Treatment/Training Project
Federation for Community Planning
1001 Huron Road
Cleveland, Ohio 44115

Family Rape Services
Cleveland Rape Crisis Center
3201 Euclid Avenue
Cleveland, Ohio 44115

Community Relations Department
Franklin Co. Children's Services
1951 Gantz Road
Grove City, Ohio 43123

Child Assault Prevention Program
Women Against Rape
P.O. Box 02084
Columbus, Ohio 43202

Child Sexual Abuse Program
Child and Family Services
535 Marmion
Youngstown, Ohio 44504

Rape Prevention Program
Consultation and Education Dept.
Columbus Area Community Mental
Health Center
1515 East Broad Street
Columbus, Ohio 43205

### OKLAHOMA

Public Health Guidance Center
Oklahoma State Dept. of Health
N.E. 10th and Stonewall Streets
Oklahoma City, Oklahoma 73105

Pediatric Psychology Service
Oklahoma Children's Memorial Hospital
Box 26901
900 N.E. 13th Street
Oklahoma City, Oklahoma 73104

Parents Assistance Center
2720 Classen Blvd.
Oklahoma City, Oklahoma 73106

**At-Risk Parent-Child Program**
**Hillcrest Medical Center and the**
**Univ. of Oklahoma, College of Medicine**
**Utica on the Park**
**Tulsa, Oklahoma 74104**

## OREGON

**Child Sexual Abuse Treatment Program**
**Child Protective Services**
**1031 East Burnside**
**Portland, Oregon 97215**

**Adolescent Victims Counseling Groups**
**Oregon Department of Human Resources**
**Children's Services Division, Reg. IV**
**1102 Lincoln Street**
**Eugene, Oregon 97401**

**Christian Family Institute Counseling**
**Services**
**1501 Pearl Street**
**Eugene, Oregon 97401**

## PENNSYLVANIA

**The Joseph J. Peters Institute**
**(formerly the Center for Rape Concern)**
**112 South 16th Street, 11th Floor**
**Philadelphia, Pennsylvania 19102**

**Incest Counseling Program and**
***Innocense* (Rap Group for Women**
**Victims)**
**Women Organized Against Rape in**
**Bucks County**
**P.O. Box 793**
**Langhorne, Pennsylvania**

## TENNESSEE

**PAASAC (Project Against Appalachian**
**Sex Abuse of Children)**
**Child and Family Services of Knox Co.**
**114 Dameron Avenue**
**Knoxville, Tennessee 37917**

**Child Sex Abuse Technical Assistance**
**Project**
**Tennessee Dept. of Human Services**
**Social Services Department**
**410 State Office Building**
**Nashville, Tennessee 37219**

## TEXAS

**Dallas Sexual Abuse Project**
**Texas Dept. of Human Resources**
**Social Services Branch**
**John H. Reagan Building**
**Austin, Texas 78701**

**Project S.E.Y. (Sexually Exploited Youth)**
**501 South Congress**
**Suite 312**
**Austin, Texas 78704**

**Child Sexual Abuse Treatment Program**
**Family Services Association**
**230 Peredia Street**
**San Antonio, Texas 78210**

**Sexual Abuse Unit**
**Dallas County MHMR Center**
**5925 Maple Avenue, Suite 113**
**Dallas, Texas 75235**

**Child Sexual Abuse Prevention Program**
**Family Service Center—Montrose Office**
**3400 Montrose, Suite 209**
**Houston, Texas 77006**

## UTAH

**Rape Crisis Center**
**Core 10 Program**
**329 East 6th South**
**Salt Lake City, Utah 84111**

## VIRGINIA

**Sexual Abuse Treatment Program**
**Virginia Dept. of Social Services**
**Municipal Center**
**Virginia Beach, Virginia 23456**

## WASHINGTON

**Sexual Assault Center**
**Harborview Medical Center**
**325 9th Avenue**
**Seattle, Washington 98104**

**Families Reunited**
**9903 24th Avenue East**
**Tacoma, Washington 98445**

**Child Sexual Abuse Treatment Program**
**Child Protective Services**
**1310 Tacoma Avenue**
**Tacoma, Washington 98404**

**Juvenile Sex Offender Treatment Program**
**Adolescent Clinic**
**Child Development and Mental Retardation Department**
**University of Washington**
**Seattle, Washington 98195**

### WEST VIRGINIA

**Sexual Abuse Treatment and Training**
**3375 Route 60 East**
**P.O. Box 8069**
**Huntington, West Virginia 25705**

### WISCONSIN

**Sexual Assault Treatment Center**
**Social Services Department**
**Family Hospital**
**2711 West Wells Street**
**Milwaukee, Wisconsin**

**Family Services of Milwaukee**
**P.O. Box 08517**
**Milwaukee, Wisconsin 53208**

**Parental Stress Center**
**1506 Madison Street**
**Madison, Wisconsin 53711**

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# APPENDIX D

## Contributing Authors

**LUCY BERLINER, M.S.W.**, has been a clinical social worker and educator at the Sexual Assault Center, Harborview Medical Center in Seattle, since the inception of the program in 1973. She was instrumental in developing the Center's specialized services for sexually abused children; she is currently co-principal investigator of the Center's LEAA sponsored project, "The Sexually Abused Child as a Victim/Witness," and a clinical instructor in the University of Washington School of Social Work.

**JEAN BIRNBAUM** is a graduate of Simmons College and was an Assistant Psychologist at the Massachusetts Center for the Diagnosis and Treatment of Sexually Dangerous Persons in Southbridge, Massachusetts.

**RONALD M. COSTELL, M.D.**, is Assistant Clinical Professor of Psychiatry and Behavioral Sciences at George Washington University School of Medicine. He is also Adult Psychiatric Consultant to the Child Protection Center, Children's Hospital National Medical Center.

**JUDIANNE DENSEN-GERBER, J.D., M.D.**, is a practicing psychiatrist and attorney who founded Odyssey House in 1966. Originally established to treat drug addiction, Odyssey House programs now provide specialized treatment for adolescents, addicted pregnant women, child abuse and neglect victims, schizophrenics, and addicted armed forces veterans. Odyssey House programs presently operate in New York, Louisianna, Michigan, New Hampshire, Utah, and Sidney, Australia. In 1975, Odyssey Institute was founded to develop specialized health care programs for the socially disadvantaged. The Institute's most recent activities have been focused on improving state and Federal legislation in the area of sexual exploitation of children through child pornography. Dr. Densen-Gerber is the mother of four children and is married to the chief medical examiner of New York City.

**RAYLENE A. DeVINE, M.D.**, is a pediatrician in the Department of Ambulatory Medicine and Pediatric Coordinator of the Birth Defects Clinic, Children's Hospital National Medical Center. She is also Clinical Instructor of Child Health and Development, George Washington University School of Medicine, and Pediatric Consultant to the National Survey of the Incidence and Severity of Child Abuse and Neglect and the American Academy of Pediatrics' Child Abuse Curriculum Project.

**HENRY GIARRETTO, Ph.D.**, is the director of treatment and training at the Child Sexual Abuse Treatment Program in San Jose, California. In 1971, he and Anna Einfeld Giarretto established the program through the Juvenile Probation Department of Santa Clara County to provide treatment that was otherwise unavailable to a handful of families with identified incest problems. The program has expanded to include all forms of child sexual abuse, and currently serves a client population that averages over six hundred referrals a year. The CSATP incorporates Parents United, Daughters United, and Sons United, self-help programs for members of incestuous families, and has developed a state-wide demonstration and training program for professionals who deal with incest problems.

**A. NICHOLAS GROTH, Ph.D.**, is Director of the Sex Offender Program at the Connecticut Correctional Institution at Somers, Connecticut. He was formerly Director of Psychological Services at the Massachusetts Center for the Diagnosis and Treatment of Sexually Dangerous Persons.

**JUDITH HERMAN, M.D.**, is the psychiatric director of the Women's Mental Health Collective, a non-profit, woman-controlled clinic in Somerville, Massachusetts. She received her medical training at Harvard Medical School and her training in general and community psychiatry at Boston University Medical Center. She is presently, with Lisa Hirschman, principal investigator of a study of father-daughter incest funded by NIMH Center for the Prevention and Control of Rape.

**LISA HIRSCHMAN, M.A., M.Ed., Ed.D. (candidate)**, is presently a clinical supervisor at the University of Montreal in the Counseling Psychology Department. She previously worked as clinical coordinator of the Cambridgeport Problem Center in Cambridge, Massachusetts. She also worked with families of disturbed children and with individual clients in various community clinics and schools in the Boston area. Her special areas of training are family therapy (she is a graduate of the Boston Family Institute), community psychology, and women's studies.

**LINDA L. JENSTROM**, is a Research Associate in the Office of Child Health Advocacy, Children's Hospital National Medical Center, and a consulting writer and editor for the Maritime Transportation Research Board, National Academy of Sciences. Formerly, she was the Infant Care Specialist for the Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc., and author of *"Improving Care for Infants of School-Age Parents."*

**BARBARA McCOMB JONES**, is a Research Associate in the Office of Child Health Advocacy, Children's Hospital National Medical Center. She was formerly Associate Editor for the Consortium on Early Childbearing and Childrearing, Child Welfare League of America, Inc., and editor of *"Adolescent Birth Planning and Sexuality: Abstracts of the Literature."*

**ANNE LOWE KNASEL, M.D.**, is a pediatrician with the Child Protection Center, Children's Hospital National Medical Center. She is also Clinical Instructor of Child Health and Development at George Washington University School of Medicine, Washington, D.C.

**JOANN KRYSO, M.S.W.**, is a senior psychiatric social worker with the Community Consultation Service of Harbor General Hospital in Torrance, California.

**KAREN M. LEAMAN, R.N., M.S.N.**, is a nurse therapist with the Crisis Intervention Service of the Psychiatric Institute of Washington, D.C. She was formerly a nurse clinician with the Child Protection Center, Children's Hospital National Medical Center.

**KEE MacFARLANE, M.S.W.**, is a program specialist at the National Center on Child Abuse and Neglect in Washington, D.C. Prior to joining the federal government, she was responsible for training and technical assistance in two state child abuse projects, and served as the coordinator of a legal assistance project for battered women. She is the co-founder of Parents Anonymous in the state of Maryland and served as a lobbyist for the legislative office of the National Organization for Women. She is a social worker whose prior experience includes several years as a therapist with abusive and incestuous families and as a caseworker in a child care institution for abused and disturbed children.

**LINDA C. MEYER, M.A.**, is the associate director for research, training, and education at the Center for Rape Concern in Philadelphia, Pennsylvania. She received her bachelor's degree from Beaver College in Glenside, Pa., her master's degree in sociology from the University of Pennsylvania, and is currently completing her dissertation for a doctorate in sociology, specializing in criminology.

**BARBARA L. MYERS** is the founder and director of the Christopher Street Incest and Sexual Abuse Program, Inc., in Minneapolis, Minnesota. The program has treated over four hundred women and adolescents since it was established in July, 1976. Its services include support groups, learnings labs, advocacy intervention, professional training, referral and consultation. She was one of three women who participated in the film, "Incest: The Victim Nobody Believes." Formerly, she was a consultant with the Bach Institute, a family therapy institute, where she was a co-therapist for an incest victims' group and a therapy group for sex offenders. In founding the Christopher Street Incest Program, she achieved a long-time goal of developing a specialized treatment program for other incest victims like herself.

**ALVIN A. ROSENFELD, M.D.**, received his B.A. in government from Cornell University in 1966 and an M.D. from Harvard University School of Medicine in 1970. He trained in adult and child psychiatry at Harvard and is Board certified in both. He has been on the faculty of Harvard Medical School and Eastern Virginia Medical School and is currently assistant professor of psychiatry and behavioral sciences and director of training in child psychiatry at Stanford University Medical Center. He has published extensively in the field of incest and child abuse and is currently involved in research on the normative sexual development in children.

**CLARA JO STEMBER, M.A., A.T.R., 1920-1978.** Mrs. Stember received her B.A. from Wayne State University, and her M.A. in art education from Adelphi University in New York. She was a registered therapist with the American Art Therapy Association and a Ph.D. candidate in art therapy at Union Graduate School of Antioch College in Ohio. Most recently, she was the consultant art therapist at the Sexual Trauma Treatment Pilot Program of the Connecticut Child Abuse and Neglect Demonstration Project, and adjunct assistant professor of art at the College of New Rochelle in New York. Formerly, she was an instructor of art education at Adelphi University, and a consultant art therapist at the Children's Bureau Demonstration Project in Suffolk County, New York. She was certified as a pilot at the age of 15, and flew in an air circus with her brothers. She was one of the first pilots to join the Women Air Force Service Pilots (WASPs), and instructed male pilots for combat duty during World War II. She is survived by her husband and two sons.

**MADDI-JANE STERN, M.S.W., A.C.S.W.**, received her M.S.W. from the University of Pennsylvania, and is a graduate of Beaver College in Glenside, Pennsylvania. She also has completed two years of postgraduate training in couple counseling and structural family therapy. She was the associate director for social services at the Center For Rape Concern in Philadelphia, and currently has a private practice in Philadelphia.

**DORIS A. STEVENS, M.A., A.C.S.W.**, has been supervisor of clinical services at the Sexual Assault Center, Harborview Medical Center in Seattle, since March, 1974. Her previous social work experiences were in the fields of women's health care and child welfare services. She is currently co-principal investigator of an NIMH sponsored research project, "Alternative Interventions for Sexual Assault Victims," and is a clinical instructor for the University of Washington School of Social Work.

**ROLAND SUMMIT, M.D.**, has been a psychiatric consultant to child caring programs for the past 13 years. He presently is the head of the Psychiatric Community Consultation Service, Harbor General Hospital, Torrance, California, and adjunct associate professor of psychiatry at UCLA. He is a founding member of the Board of Directors of Parents Anonymous, and has been active in that organization since 1971. In 1978, he served as chairperson for the Interagency Task Force to develop a sexual abuse treatment program for Los Angeles County. He is a member of the Long Beach Child Trauma Council, as well as several child abuse advisory panels.

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